

WORKING PAPER **312**

# Painful Tradeoffs: Intimate-partner Violence and Sexual and Reproductive Health Rights in Kenya

Joanna Crichton, Celestine Nyamu Musembi, and Anne Ngugi  
October 2008

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## **Painful Tradeoffs: Intimate-partner Violence and Sexual and Reproductive Health Rights in Kenya**

**Joanna Crichton, Celestine Nyamu Musembi, and Anne Ngugi**

### **Summary**

Intimate-partner violence involves multiple violations of sexual and reproductive rights, with devastating impacts on the health and wellbeing of those affected. This paper is the result of an action-research collaboration between a Kenyan gender-based violence rehabilitation NGO and a research programme. Qualitative and descriptive quantitative analysis of seven years of client records were carried out to investigate women's experiences of intimate-partner violence and their responses to it. The paper departs from the observation that international human rights, while profoundly conceptually relevant to Kenyan women, are frequently practically irrelevant to their lives. Instead, various and often contradictory forms of rights, or legitimate claims, co-exist and interact in personal beliefs, in social relationships and in national legal and judicial systems. We therefore seek to contextualise rights in the lives of women affected by intimate-partner violence, to understand how they are articulated and constrained in each of these dimensions. We find that physical and sexual abuse within relationships often leads to repeated exposure to sexual and reproductive health risks, and abused women lack knowledge about these impacts, experience feelings of hopelessness about their health, and are unable to access the health services they need. Economic factors lead many women to subordinate their sexual and reproductive rights to their material needs and those of their children. There are limitations to the recognition of rights in both social attitudes and in the national legal framework. Social networks and justice institutions sometimes support individuals in exercising their rights and sometimes obstruct them. Legal reform, and strengthened services and referral systems are needed if the barriers to women's rights are to be overcome. Measures to facilitate access to sexual and reproductive health services and to address forms of vulnerability in ongoing abusive relationships are needed to help those affected to end the violence and mitigate its impacts.

**Keywords:** intimate-partner violence; sexual and reproductive health; rights; service delivery; Kenya.

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# Preface

Between November 2005 and May 2006, the Nairobi-based NGO the Women's Rights Awareness Programme (WRAP) and the Research Programme Consortium (RPC) on Realising Rights: Improving Sexual and Reproductive Health for Poor and Vulnerable Populations, collaborated to explore the relationships between gender-based violence and sexual and reproductive health and rights. Researchers from two RPC partners, the Institute of Development Studies (IDS) and the African Population and Health Research Center (APHRC), worked with WRAP to analyse seven years of their client records. This working paper is a product of this partnership, and was written by the Director of WRAP and researchers from IDS and APHRC. As part of the project, one of the researchers helped WRAP to develop a new system to more systematically capture, store and make use of their client records. This has helped to strengthen service delivery and monitoring, and increased WRAP's ability to analyse their data and share the lessons learned with policymakers and other service providers.

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## Abbreviations

APHRC	African Population and Health Research Center
CREAW	Centre for Rights Education and Awareness
COVAW	Coalition on Violence Against Women
DfID	UK Department for International Development
FIDA Kenya	Federation of Women Lawyers Kenya
IDS	Institute of Development Studies
LVCT Kenya	Liverpool VCT Kenya
SRH	Sexual and Reproductive Health
STI	Sexually-transmitted infection
CEDAW	The United Nations Covenant on the Elimination of All Forms of Discrimination Against Women
VCT	Voluntary Counselling and Testing
WRAP	Women's Rights Awareness Programme

# 1 Introduction

Gender-based violence involves multiple violations of human rights and has debilitating effects on the health and wellbeing of those affected. It is an issue of urgent international attention and concern, a trend mirrored in Kenya, where official figures demonstrate that at least half of all women have experienced violence since they were aged 15 (CBS 2004b), and where advocacy groups have continued to raise the profile of violence against women in media, policy and legal fora. The term violence against women describes a range of practices, including physical, sexual and psychological violence by intimate partners and other family members, dowry-related violence, marital rape, forced sex work, and female genital mutilation (DEVAW 1993). This study examines a particular form of violent relationship, intimate-partner violence (IPV), or physical, sexual or emotional abuse by spouses or other sexual partners, focusing on IPV against women.

Between November 2005 and April 2006, the Women's Rights Awareness Programme (WRAP), the Institute of Development Studies (IDS), and the African Population and Research Center (APHRC) collaborated in an action research project to explore the relationships between gender-based violence and sexual and reproductive health rights in Nairobi. WRAP is a Nairobi-based NGO that provides counselling, shelter, mediation, legal advice and referral services to survivors of gender-based violence in Nairobi (see Box 1.1).

The purpose of the collaboration was to enable WRAP to systematise the information they collect on their clients, and to analyse and communicate the lessons learned from WRAP's ten years of experience as a frontline service provider. WRAP's everyday work generates valuable information about clients, the abuse they have experienced, the problems they face, and the services WRAP provides in response. From their experience, WRAP staff had identified that health conditions related to abuse, including sexual and reproductive health conditions, are major problems affecting their clients. WRAP believed that their client records created between 1999 and 2005 were an important source of information on violence and sexual and reproductive health, but did not have the capacity to organise and analyse the data. Through collaboration with IDS, qualitative textual analysis and quantification of basic client demographic data were carried out for 1,253 of their records that concerned intimate-partner violence, from this time period. Analysis of these records enabled WRAP to explore the potential for using their client information to generate policy-relevant lessons, to improve their services, and to develop the capacity to carry out future research and advocacy. In addition, semi-structured interviews were carried out with staff of organisations providing services to survivors of violence, to relate the experiences of WRAP to the wider network of partner organisations in the health, legal and rehabilitation sectors in Nairobi.

WRAP helps women and child clients affected by a range of types of violence, but we chose to focus on intimate-partner violence in this study because it affects the majority (70 per cent) of WRAP's clients. Intimate-partner violence, and its sexual and reproductive health impacts, involve multiple and often mutually reinforcing rights violations. In Kenya as in many contexts around the world, these rights are articulated in international law and to varying degrees in national law, but, there

are vast gulfs between formal legal rights and the realities experienced by individuals. These disconnects are a central concern of this paper, and engender the need to broaden analysis of rights beyond the content and implementation of laws, to investigations of what rights mean in practice, and how they are defined, claimed, contested and ultimately realised or violated in particular contexts. In this paper, we define rights broadly, as 'legitimate claims', whose legitimacy can flow from multiple sources in addition to formal law. The socio-cultural context and an individual's own consciousness, for instance, play important roles in determining which rights are accorded legitimacy in different domains. In order to understand weaknesses in the content of national laws and in their implementation, it is necessary to examine legal and justice institutions as contexts where rights are understood in different ways by different actors and where legal rights interact with customary and religious law and practice. Not all individuals are aware of their rights, or take action aimed at making them a reality. Finally, the social sphere, including families and communities, plays a role in defining which claims or entitlements are socially legitimated, and can either protect individuals' entitlements or violate them further. In sub-Saharan African and elsewhere, this is particularly true of issues such as sexual and reproductive health, which involve social and cultural beliefs and practices, and are traditionally influenced and regulated by the social sphere.

### **Box 1.1 The Women's Rights Awareness Programme (WRAP)**

WRAP was set up in 1994 to provide rehabilitation services to survivors of gender-based violence (including intimate-partner violence, child abuse and rape) in Nairobi. WRAP is one of very few NGOs offering secure shelter in a confidential location to women and children in Kenya. WRAP also provides a range of other services to shelter and walk-in clients, including counselling, practical and legal advice, covering the cost of transport and certain medical conditions, mediation with partners and families, child welfare and housing services, small-business start up costs, and referral to organisations that can meet their medical, legal aid and other needs.

The intersections and disconnects between the social, legal and personal dimensions of rights are a central concern of this paper, and help us to understand the circumstances under which women seek medical, legal or rehabilitation services, and to understand the factors that may prevent them from accessing these services.

This paper therefore aims to understand the constraints individuals affected by intimate-partner violence face when seeking to realise their sexual and reproductive rights. A 'three dimensional rights framework' (described in Section 3) is used to analyse these constraints and their implications for policy and practice on gender-based violence and sexual and reproductive health. The research questions were developed through discussions between WRAP and IDS and APHRC researchers. The study investigated (i) the impacts of intimate-partner violence on the sexual and reproductive health and rights of WRAP's clients,

(ii) how individuals conceive their rights relating to sexual and reproductive health, (iii) how these rights are defined, protected and constrained in social and legal contexts, (iv) how different forms of vulnerability affect individuals' ability to protect themselves from violence or mitigate its impacts. Finally, the implications for WRAP, other service providers and policymakers were drawn out. This paper is structured as follows. Section 2 provides an overview of sexual and reproductive rights in international law, the impacts of intimate-partner violence on sexual and reproductive health, and existing research on intimate-partner violence in Kenya. Section 3 introduces an analytical framework for understanding the three dimensions of rights and how these affect survivors of intimate-partner violence. The methodology used in the study is described in Section 4. Section 5 presents the study findings, including on the impacts of intimate-partner violence on sexual and reproductive health, the scope and limitations of the personal, social and legal dimensions of rights, and the implications for service delivery. Section 6 discusses these findings and Section 7 concludes.

## 2 Intimate-partner violence and sexual and reproductive health rights

Sexual and reproductive health (SRH) and rights are central to individual physical and mental wellbeing, and are essential for healthy pregnancies and childbirth and the avoidance of STIs including HIV and AIDS. They are also fundamental to many development goals, including those related to health, gender equity and poverty reduction. Sexual and reproductive health rights are multifaceted, combining a host of human rights articulated in different international treaties, conventions and statements. Sexual and reproductive rights and their relationship to international human rights documents were defined in the Programme of Action of the International Conference on Population and Development (1994), held in Cairo in 1994, and the Beijing Declaration and the Platform for Action (1995), developed at the Fourth World Conference on Women in 1995. Box 2.1 presents one formulation of the aspects of international human rights that make up sexual and reproductive health rights, all of which can be violated by intimate-partner violence. There is no official definition of sexual and reproductive health rights among international organisations, although the WHO has produced unofficial working definitions (WHO undated).

Sexual and reproductive rights can be grouped into the two main areas: (i) the right to make autonomous, informed decisions about reproduction and to be free from violence, discrimination and coercion in relation to sex, reproduction and marriage, and (ii) the right to accessible, high quality and appropriate reproductive and sexual health services (Centre for Reproductive Law and Policy and University of Toronto 2002). The right to non-discrimination and respect for difference requires governments to ensure equal access to health care for all, and to address the gender-specific health needs of women and men. To fulfil people's rights to life and health, governments must make comprehensive reproductive health services available and remove barriers to care (PAHO 2003).

### **Box 2.1 Sexual and reproductive health rights as human rights**

The following formulation of sexual and reproductive health rights defined in international human rights law was developed by the Centre for Reproductive Law and Policy (now the Center for Reproductive Rights) and the University of Toronto (2002):

- The right to life, liberty, and personal security
- The right to health, reproductive health, and family planning
- The right to decide the number and spacing of one's children
- The right to consent to marriage and to equality in marriage
- The right to privacy
- The right to be free from discrimination
- The right to be free of traditions and customs that violate rights
- The right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment
- The right to be free from sexual violence
- The right to enjoy scientific progress and to consent to experimentation.

These rights are defined in international instruments such as the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the United Nations Covenant on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the UN Convention on the Rights of the Child. The African Union adopted the Protocol on the Rights of Women in Africa in 2003, which articulates the rights to sexual and reproductive health, to control one's own fertility and to determine the number and spacing of one's children, to protect oneself from STIs, including HIV and AIDS, and to be informed about the health status of one's partner. At the time of writing, Kenya has ratified CEDAW, and the African Charter on Human and Peoples' Rights, but has yet to ratify the Protocol on the Rights of Women in Africa (African Union 2007). The Kenyan Government's commitment to reproductive rights is expressed in the 2007 Reproductive Health Policy (Government of Kenya 2007).

## **2.1 The sexual and reproductive health impacts of violence**

The health impacts of intimate-partner violence have been traced in a number of studies in both Northern and Southern contexts, reviewed by Campbell (2002). Intimate-partner violence involves serious and debilitating physical and mental health impacts for survivors (World Health Organisation 2005). The sexual and reproductive health impacts of these are often some of the most severe and long-lasting, and include HIV and other sexually-transmitted diseases,



complications of pregnancy, vaginal bleeding or infection, fibroids, sexual dysfunction, genital irritation, pain on intercourse, chronic pelvic pain, and urinary-tract infections (Campbell 2002; PAHO 2003). Mental health impacts associated with intimate-partner violence include depression, anxiety, emotional distress and suicidal thoughts (Krug *et al.* 2002; World Health Organisation 2005). Violence against women has been found to be associated with behavioural impacts such as sexual risk taking (Bott *et al.* 2004), therefore leading indirectly to further sexual and reproductive health problems among abused women.

There is a well developed literature on the multiple linkages between gender inequality, intimate-partner violence and limited ability to negotiate condom use and risk of HIV infection in sub-Saharan Africa, much of it focusing on South Africa. These include studies that demonstrate an association between intimate-partner violence and increased risk of HIV infection (Maman *et al.* 2002; Dunkle *et al.* 2004). Discussions about HIV within couples and disclosure of status are often associated with intimate-partner violence (Human Rights Watch 2003b). Power inequalities within sexual relationships play a strong role in undermining individuals' sexual autonomy and influence over use of condoms, and these factors are known to be reinforced by violent sexual relationships (Blanc 2001).

Few existing studies on sub-Saharan Africa explicitly examine the sexual and reproductive rights dimensions of intimate-partner violence, or the experiences of women affected by intimate-partner violence in seeking to end the violence or mitigate its effects. This study seeks to address this by investigating the multiple linkages between intimate-partner violence, sexual and reproductive risks, and rights violations, based on testimony from survivors of violence.

## 2.2 Gender-based violence in Kenya

This section situates the analysis within the wider context of gender-based violence in Kenya. Firstly, existing studies show that the high prevalence of various forms of gender-based violence, including intimate-partner violence, are a cause for concern in Kenya. According to Kenyan government statistics based on a demographic household survey carried out in 2003, 50 per cent of women in Nairobi have experienced violence since they were aged 15 (CBS 2004b). In the same study, one in four Kenyan women (and one in five women in Nairobi) were found to have experienced violence during the 12 months before they were interviewed. Intimate-partner violence was the most common form of violence cited. 42 per cent of ever-married women reported physical or sexual violence from their current or most recent partners. Marital rape appears to be common, with 15 per cent of currently married women reporting ever having been raped by their partners, and 12 per cent having experienced this during the 12 months preceding the study.

Despite the existence of official statistics highlighting the magnitude of gender-based violence in Kenya, funding for the violence rehabilitation, justice and medical sectors remains limited and demand for services far outstrips supply. The Government of Kenya does not directly provide rehabilitation, legal aid or other support services for survivors of violence, leaving provision to NGOs and other

private organisations. NGOs such as Liverpool Voluntary Counselling and Testing (LVCT) and Nairobi-Women's Hospital have led the way with post-rape service provision in Kenya. Comprehensive care for survivors of rape combines counselling services for the survivor and their families, clinical physical examination and treatment, STI/HIV and pregnancy prophylaxis, evidence collection and documentation, sample handling and analysis (Kilonzo 2003). These services are open to anyone affected by sexual violence, but are targeted at emergency care for single episodes of abuse rather than tackling broader or recurrent health needs related to ongoing cases of violence within relationships. The Ministry of Health has made some progress by introducing clinical guidelines for post-rape services in 2004 (Government of Kenya 2004) and extending these services to government hospitals, but one key informant for this study explained that converting these guidelines into accessible services is a slow process, and comprehensive post-rape services are often only available at the Provincial level. In general, relevant services are clustered in Nairobi, and service provision remains patchy or non-existent outside the capital city. There is also poor coordination between different sectors whose mandates cover intimate-partner violence (Kilonzo 2003).

Few studies to date have investigated the impacts of violence on sexual and reproductive health in Kenya. In a survey undertaken by the Kenyan chapter of the Federation of Women Lawyers (FIDA Kenya) of 1,067 women attending antenatal clinics and emergency care at a range of Nairobi hospitals, 0.4 per cent reported miscarriage caused by domestic violence, and 0.7 per cent reported STIs (FIDA Kenya 2002a). This may be an underestimation of the SRH impacts of violence due to the sensitivity of the subject, and larger population studies are needed to generate reliable estimates of prevalence rates of SRH problems due to violence in Kenya. Existing studies hint at the personal, social and institutional barriers to SRH rights in the context of intimate-partner violence. A study carried out by Amnesty International found that over half of Kenyan women who knew they were HIV positive had not disclosed this to their partners for fear of violence and abandonment (Amnesty International 2002). Fifty-six per cent of the abused women in FIDA Kenya's 2002 survey said that they had not reported the violence to anyone, with many stating that violence is considered to be a normal part of life. A total of just seven per cent reported to the chief, the police or a doctor (FIDA Kenya 2002a).

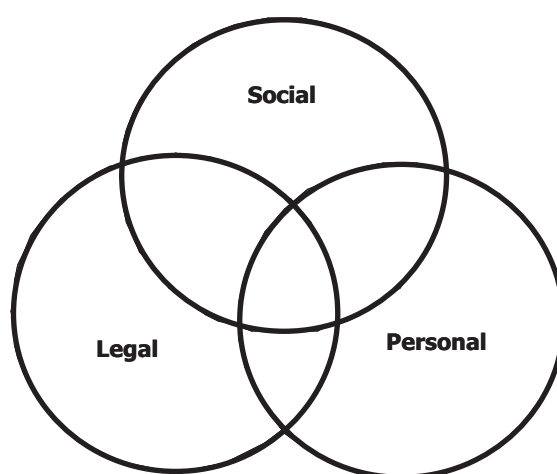
### 3 Conceptual framework for contextualising sexual and reproductive rights in relation to violence against women

Rights articulated in international human rights law are far from being a reality for many Kenyan women. Abstract, legal and individualistic concepts of rights may be inadequate for capturing the multiple and often ambiguous nature of rights as they



are experienced by individuals, and the multiple constraints they face in exercising them. The reasons for this include weaknesses in legal and judicial systems, inadequate health and other services, and contradictions between legal and socio-cultural concepts of rights. This paper uses a framework developed in an earlier publication (Crichton *et al.* 2006), in which rights are defined as 'legitimate claims', where legitimacy is based on three intersecting dimensions: social, legal and personal (see Figure 2.1). By contextualising sexual and reproductive health rights in these three dimensions, it is possible to identify the constraints faced by individuals in realising their human rights in contexts of intimate-partner violence.

**Figure 2.1 Three dimensions of rights**



The **social dimension** of rights consists of claims that are legitimised variously by religion, ideology, traditions, culture and general social assent. In Kenya, as in other sub-Saharan African countries, intra-family and community norms and practices for regulating relationships play an important role in facilitating or constraining people's ability to articulate and exercise their rights (Nyamu-Musembi 2002). In Kenya, the social context can in some cases legitimise and protect SRH rights, for example where there are social sanctions for abusive behaviour. It can also constrain sexual and reproductive rights, where rights violations such as violence against women are socially condoned in certain circumstances (Hirsch 1998; Heise 1998). Power plays an important role in how culture and tradition are socially constructed, including where individuals or groups invoke particular versions of tradition to legitimise domestic violence and other rights violations (Hernández Castillo 2002).

The **legal dimension** of rights includes both the content of law and the *de facto* functioning of legal and judicial systems, which in practice may either protect or violate rights. Legal rights are defined in international and national law, but in pluralistic legal contexts such as Kenya, interact with customary and religious law and practice. In Kenya, local administration plays a default role in family dispute resolution and may have positive or negative implications for gender equality in different cases (Nyamu-Musembi 2002). Limitations to Kenya's legal framework that undermine the rights of women affected by intimate-partner violence include weak legislation, such as the failure to prohibit marital rape, and ambiguities concerning abortion law and the legal status of cohabitation relationships (FIDA

2002b; Kabeberi-Macharia and Nyamu 1998; Kilonzo 2003). Legally defined rights may be poorly enforced due to institutional weaknesses and gender bias in justice institutions (Kilonzo 2003: 65).

The **personal dimension** concerns how individuals perceive their rights, based on their social position and knowledge and beliefs about the other two spheres. Personal definitions of rights are complex, involving the interaction between social identities, experiences, messages from education, the media and the multiple influences from the social dimension. Women may internalise and rationalise rights violations that are legitimated in the social dimension. For example, some women in East African and other contexts accept intimate-partner violence as legitimate, based on cultural norms that husbands have the right to 'correct' wives who do not adequately fulfil their roles of a 'good wife' (Ezeh and Gage 2000; Heise 1998). This highlights the need to start analysis from women's own sense of entitlement, or their subject perception of their rights, the 'space between a sense of need and the articulation of a right' (Petchesky 1998). Even where individuals are aware of their rights, their ability to claim them depends on their control over political, social and material resources and their ability to access formal and informal institutions that can help them to realise their rights.

In Kenya, as in other contexts, two sets of factors are likely to have particularly important impacts on all three of these dimensions and ultimately on the ability of individuals to realise their rights. Firstly, the economic resources at the disposal of an individual can impact on their ability to claim their rights and mobilise support for them in both the social and the legal realms. Women's lack of financial independence has been found to be a risk factor for intimate-partner violence (Heise 1998), and gender inequalities reinforced by intimate-partner violence can undermine women's access to money and other resources within the household, potentially undermining their access to health services (Blanc 2001). Low income levels and socioeconomic status can affect individual's access to justice institutions, particularly in contexts where prejudice, discrimination and corruption are common among frontline justice officials (Narayan *et al.* 2000).

Secondly, socially constructed gender beliefs and norms about the differential entitlements and responsibilities of women and men within relationships can have an impact on all three dimensions of rights, shaping senses of entitlements and responses from social networks and justice institutions (Hirsch 1998; Nyamu-Musembi 2002). Kabira *et al.* (1997) highlight the importance of taken-for-granted norms that influence male/female relationships and rationalise gender subordination in Kenya, and examine how these norms are reproduced through cultural forms of expression such as folklore and idiom among various ethnic groups.

All over the world, intimate-partner violence involves power inequalities. In Kenya and other sub-Saharan African countries, these gendered power inequalities are often magnified by the social legitimisation of patriarchal values and by discriminatory laws and institutions. Rights in this context may be especially constrained in all of the three dimensions. Supportive factors and constraints experienced by WRAP clients in these different dimensions are explored in turn in Section 5, below.

## 4 Methodology

The study involved qualitative analysis of information on WRAP's clients, collected during routine service delivery between 1999 and 2005. Each record corresponds to one or more meetings between the client and WRAP staff.<sup>1</sup> This information was not collected for research purposes. It was volunteered by clients during interviews with WRAP's social workers, who work by encouraging the client to tell their story in their own words. WRAP's records from the study period 1999–2005 are narrative records where information such as marital status or level of education were not consistently recorded.<sup>2</sup> For example, information on the type of relationship (customary, formal marriage or cohabitation) are available for only 18 per cent of the 1,672 cases of clients that were married or in a relationship. The staff wrote up the case history once the client had left the room, so that the client received undivided attention and was not intimidated by notes being taken. The routine service delivery context therefore tended to involve a different dynamic between informant and field worker to interviews conducted for research purposes. Clients may have been more comfortable disclosing sensitive information to a social worker than they would have been to a researcher.

The meetings were carried out and recorded by the social worker in KiSwahili. The records were later translated into English and typed up in a word processing package, coded and anonymised by WRAP staff members. External researchers involved in the project viewed only the anonymous data. The quotations from records below have been edited for spelling and grammatical errors but are otherwise reproduced here verbatim using the phrasing recorded by the translator.

WRAP have 2012 client records from the period 1999–2005. Of these, information on the client's relationship with the abuser was recorded in 1,795 records. Intimate-partner violence affected 1,253, or 70 per cent, of the records which had information on the relationship between the client and the abuser. All of the 1,253 client records relating to intimate-partner violence were analysed. The records consisted of narrative case histories describing the client's personal circumstances, the type of abuse they have experienced, the strategies they had taken and problems encountered, their needs from WRAP, and the action WRAP staff took in response. Most records were between 100 and 300 words in length, although some were as long as 1,000 words.

Qualitative analysis of the case histories was carried out using grounded theory methodology (Strauss and Corbin 1998; Lempert 1997). Case records were analysed as texts rather than factual accounts (Ulin *et al.* 2005),<sup>3</sup> to look for insights into how WRAP's clients conceptualised and experienced the violence, its sexual and reproductive impacts, and the processes through which they sought to end the violence or mitigate its effects. Based on a preliminary reading of the

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1 Only a few cases of multiple records for the same individual were identified, and in these cases, the multiple records were grouped together and treated as one record.

2 As a result of this project, WRAP has since introduced structured client record forms, which include set questions for clients so that they consistently record essential information.

records, recurrent themes and subthemes were identified. These themes were discussed with WRAP staff, and the characteristics of themes and their inter-relationships were explored. A sub-sample of 400 records from the years 1999 and 2005 were coded in line-by-line analysis using the themes. The remaining 853 records were carefully read to verify the consistency of themes across all seven years of data, to identify additional themes, and to select examples for citation.

For each record, basic demographic data was entered into a database, and simple descriptive quantitative analysis was carried out. Quantitative analysis of the data was limited by the fact that the information was not collected systematically. Individual records included different combinations of variables and it was not possible to use statistical analysis to look at the relationships between variables. However, it was possible to generate frequencies and percentages on the more commonly recorded data such as age, place of residence and type of abuse, which provide information on the characteristics of the sample population, described in Section 5.1. A limitation of the client records for both qualitative and quantitative analysis was that the ethnic group of the client was not recorded, and information on the client's home district was only occasionally recorded, so it was not possible to identify variations in the social dimensions of rights between ethnic groups.

Between December 2005 and March 2006, semi-structured interviews were carried out with six staff of the Nairobi-based service providers of Federation of Women Lawyers (FIDA) Kenya, Liverpool VCT (LVCT) Kenya, Nairobi Women's Hospital, the Centre for Rights Education and Awareness (CREAW), the Coalition on Violence Against Women (COVAW), and The CRADLE Children's Foundation, to collect background information on the referral system for survivors of gender-based violence in Nairobi.

WRAP did not systematically ask respondents about the health impacts of abuse, because for most of the years in which the data was collected, WRAP did not have funding to offer medical services related to sexual and reproductive health, such as payment of medical costs. However, many clients brought up health problems as part of their descriptions of abuse. Symptoms rather than professional diagnosis of conditions were recorded. Many had not accessed medical services and their conditions had not been diagnosed. In other cases, clients may not have communicated information on their diagnosis to WRAP's staff. A medical general practitioner working with APHRC provided assistance in identifying possible SRH conditions the reported symptoms or combinations of symptoms might relate to. The broad categories listed below in Section 5.2 are just an indication of what the SHR morbidities may be, not proven diagnoses and should be interpreted with this in mind, since no medical examinations were carried out on the clients.

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3 Analysing the records as texts involves careful reading of the narrative accounts provided by clients in order to develop understandings of what clients experienced and thought about the abuse and its impacts. The ways in which they described these impacts to WRAP staff, including the issues that they considered important to raise, are particularly illuminating for understanding, for example, how women conceptualise the entitlements and responsibilities of men and women in relationships, and how they experienced the health impacts of violence.

Using existing NGO data involved limitations, which have been taken into account when analysing and interpreting the data. As described above, no analysis of relationships between variables was possible due to the lack of consistency in the information recorded in client records.

Although the risk of bias arising from the dynamic between researcher and informant was reduced by using data collected for other purposes than research, this study involves alternative risks of service delivery bias, where clients may misrepresent their circumstances because they believe this may help them to get more assistance. The client records were written by WRAP staff after the meeting had finished, which means that the stories are filtered by the memory and assumptions of the staff member. It was therefore important to focus on recurring themes rather than single cases and to discuss the emerging themes with WRAP staff during analysis. We triangulated the findings relating to the legal and service delivery contexts with key informant interviews. We also triangulated the study findings on the experiences of WRAP's clients by continually relating them to the findings of other studies in Kenya and elsewhere in East Africa.

This study went through internal ethical review at the second author's institution and was considered to not involve human subjects because the data were not collected for the purposes of the study, and were anonymised, so it was not possible for the investigators to identify the individuals to whom the data pertains.<sup>4</sup> Carrying out research on GBV with human subjects involves risks of harm to informants and researchers. This approach had the advantage that the study utilised a valuable source of existing information, rather than carrying out new research, thus maximising the benefits of carrying out the research relative to the risks involved. As an action research project, the research was carried out in a way that would build WRAP's capacity to record, manage, analyse and communicate their data for service delivery and monitoring, research and advocacy.

## 5 Rights in context: violence and the three dimensions of rights

In this section, we present the study findings, including background information on WRAP's clients and the impacts of violence on sexual and reproductive health rights. We explore the strengths and limitations of the personal, social and legal dimensions of rights for protecting abused women's sexual and reproductive health rights. We also examine the constraints faced by service providers in responding to intimate-partner violence.

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4 The study is therefore considered to be exempt from the requirements of informed consent, as outlined in the United States government regulations on research ethics (United States Department of Health and Human Services 2005: Section 46.101 part (b) paragraph 4). The Kenyan government has guidelines on research involving human subjects (National Council for Science and Technology 2004), but these focus on biomedical research and only cover the case of using medical records, rather than records from other service providers.

## 5.1 Characteristics of WRAP's clients affected by intimate-partner violence

Intimate-partner violence affected 70 per cent (1,253) of the 1,795 of WRAP's clients whose records featured information on their relationship with the abuser. Out of the 1,253 of WRAP's clients affected by intimate-partner violence, 110, or around nine per cent, explicitly mentioned sexual abuse. This may be an under-estimation of those affected, as many clients may not volunteer this information due to the stigma associated with sexual violence.

1,234, or 98.5 per cent of WRAP's clients affected by intimate-partner violence, were female. Nineteen clients were male, with two experiencing physical abuse from their female partners, and the remainder experiencing psychological abuse and neglect. Table 5.1 shows the age distribution of WRAP's clients affected by intimate-partner violence for a sub-set of records where age information had been recorded. Almost half were in their 20s, and 37 per cent were in their 30s. 23 per cent were aged 24 or under, so are part of the 'youth' category, known to be a vulnerable group for sexual and reproductive health problems (Government of Kenya 2006b).

**Table 5.1 Age distribution of WRAP's clients affected by intimate-partner violence**<sup>5</sup>

Age	Frequency	Per cent
15–19	35	4.5
20–24	135	17.5
25–29	217	28.1
30–34	180	23.3
35–39	106	13.7
40–44	54	7.0
45 or over	43	5.6
<b>Total</b>	<b>772</b>	<b>100</b>

Just over a fifth were resident outside Nairobi, indicating both the high levels of migration in and out of the capital, and the fact that some women are prepared to travel far to access services that are not available in rural areas. Of WRAP's clients who were resident within Nairobi, 66.5 per cent came from locations which, according to government estimates, have a poverty headcount greater than 45 per cent (CBS 2003). These areas are almost exclusively informal settlements, or slums.

WRAP's records reveal a wide range of types of violence. Physical violence by intimate partners described by WRAP's clients involved kicking, hitting, burning,

<sup>5</sup> Data on the client's age was available in 772, or 62 per cent, of WRAP's client records.



biting, strangling, threatening with weapons (such as guns, *rungu* (clubs), *panga* (machetes), stoves, scalding milk, knives, hammers), assault with weapons (knives, *rungu*, stoves, scalding milk, stools, hammers, pieces of wood and metal bars), and being thrown out of the house for the night. This reveals that physical violence against women by their partners goes far beyond the beatings that are generally imagined in public discussions of violence in Kenya, although the question of whether forms of intimate-partner violence are becoming increasingly severe in Kenya, as argued by a key informant from FIDA Kenya, is beyond the scope of this paper. Sexual violence involved rape and other forced sexual acts and harassment. Psychological abuse included controlling behaviour and bullying, appropriation of earnings, emotional and financial neglect, social isolation and destruction of belongings.

In addition to the SRH problems described in Section 5.2, clients also described injuries including chronic pains, lost teeth, damage to sight or hearing, burns/scalds, loss of consciousness, fractures, and neurological impacts such as impacts on memory and speech. Some clients complained of depression, suicidal thoughts, anxiety, confusion, hypertension, and dizziness, hinting at the mental health impacts of violence.

The sample consists of women who accessed WRAP's services in Nairobi, so it is not representative of all women affected by intimate-partner violence in Kenya's national demographic make-up. Some of the factors that are likely to shape the sample population include the type of services WRAP provides, the severity and duration of the violence, differential levels of awareness of WRAP's services and access to them, and WRAP's geographical location. WRAP's clients are likely to be a minority among those affected by intimate-partner violence, as they have been motivated to seek, and were able to access, WRAP's services. The study sample excludes individuals who were able to successfully realise their rights through other channels (such as through paying for legal and medical services or through social networks) and individuals who were not aware of their rights, were not motivated to seek help, or were unable to travel to the WRAP office.

## **5.2 The impacts of violence on sexual and reproductive health and rights**

This section investigates the relationships between intimate-partner violence and violations of the right to health, the right to be free from violence, discrimination and coercion in relation to sex and reproduction, and the right to access healthcare.

The most common of the direct impacts of intimate-partner violence on sexual and reproductive health in WRAP's client records were trauma and infections of the reproductive tract, sexually-transmitted infections including HIV, and complications associated with abuse during pregnancy. WRAP's clients described how sexual abuse from their partners led to experiences of discomfort, pain, and humiliation, and feelings of anxiety caused by living with ongoing exposure to HIV and other STIs. Pregnancy appears to be a time of increased vulnerability to physical and emotional abuse and neglect for WRAP's clients. In some cases, abusive partners

tried to force WRAP's clients into seeking unsafe abortions, or clients described how becoming pregnant in an abusive relationship made them consider seeking abortions from informal providers, leading to further health risks. Box 5.1 provides a sense of the common sexual and reproductive health aspects of violence described by WRAP's clients and the multiple sexual and reproductive rights violations involved. Many clients describe difficulties accessing health services for economic reasons, including cases where the abusive partners were neglecting them financially or refusing to let them work.

### **Box 5.1 The sexual and reproductive health impacts of violence for WRAP's clients <sup>6</sup>**

*She has lived with the husband for 3 years and is blessed with 2 children. Her husband forces her into sex even after her operation, which led to complications and heavy bleeding. Her in-laws have tried to talk to him but he has not changed at all. She continues with the pains but nurses the wounds on the private parts with warm water and salt. She has noted that they have healed significantly however she is still in pain and wants to know whether WRAP can refer her to where she can receive medical care.*

(Female client aged 21, 2003)

*Before I realised he was hitting me with a piece of wood. In an attempt to block him from hitting my head, he hit my arm, which is now swollen. He pulled me from the bed and started kicking me [...] despite the fact that I'm six months pregnant.*

(Female pregnant client aged 20, 2000)

*She conceived her 3 year old and things started going wrong. He changed, became violent and brought her many STDs which she could not even manage to treat. She tried denying him sex but he would batter her seriously.*

(Female client aged 18, 2003)

As explained in Section 4, WRAP's client records do not systematically record data on medical symptoms or conditions and where details of health problems are provided, usually only the symptoms are available. Table 5.2 links SRH symptoms mentioned by WRAP clients with potential reproductive conditions they may relate to.

<sup>6</sup> The examples in Box 5.1 are selected extracts from the 1,253 client case histories analysed during this study. No single record is a representative example of the SRH impacts described in this section, but the selected records do provide an indication of some common experiences described by clients.



**Table 5.2 Sexual and reproductive health symptoms and possible conditions among WRAP's clients**

Symptoms described by clients	Potential associated SRH conditions
Genital sores, abrasions, irritation	Ulcers due to STIs (syphilis, chancroid, herpes), or abrasions or bruises resulting from violent sex
Lower abdominal pains	A variety of possible causes, including complications of an STI leading to infection in the pelvic region including the fallopian tubes
Pain during sex	Ulcers arising from STIs, or abrasions or bruises resulting from violent sex
Pain on urinating	STI and other forms of reproductive tract infections
Difficulty walking	STI and other forms of reproductive tract infections and genital abrasions
Bad-smelling vaginal discharge; urethral discharge	STIs (gonorrhea, trichomonas vaginalis). Other infections such as vaginal candidiasis
Heavy vaginal bleeding during pregnancy	Antepartum haemorrhage, for example due to the tearing away of the placenta following physical trauma on the abdomen

### **5.2.1 Forced sex and sexual and reproductive health impacts**

One of the most common forms of abuse resulting in SRH problems described by WRAP's clients was rape by intimate partners. Many of those affected described forced sex as one of the main problems relating to the violent relationship, because of its psychological impacts, the pain and violence that accompanies it, and because of ongoing exposure to the risk of HIV and other STIs. Clients described sexually-transmitted infections and symptoms of chronic abdominal pain, genital wounds and sores, pain walking and urinating, and vaginal and urethral discharge resulting from repeated forced sex by intimate partners. Cases that specify the particular STIs contracted from sexual violence in abusive relationships are rare, but among these, gonorrhoea, syphilis and HIV are named.

Recurrent marital rape and reinfection with STIs makes medical treatment difficult, particularly if the abusive partner refuses to undergo testing or treatment.

*Her husband is tormenting her, he is a drunkard and becomes very violent when he is drunk. He moves around with women and has re-infected her with various diseases every time they sleep together. He then turns around and blames her for infecting him.*

(Female client 2000, age not recorded)

*[The client's husband] also infected her with STD. She was treated and he infected her again. Every time she told him to go for treatment he refused. He treats himself with traditional herbs. He re-infected her three times and she was still sick.*

(Female client aged 28, 2003)

STIs, particularly HIV, are a sensitive and emotive issue, often involving conflict within relationships. Prevention, testing and treatment for HIV are often undermined by conflict and violence centering on accusations of unfaithfulness. As illustrated in Box 5.2, a number of clients described how HIV disclosure or discussion about HIV with their partners triggered episodes of violence.

### **Box 5.2 Linkages between intimate-partner violence and HIV**

*She went for [Voluntary Counselling and Testing (VCT)], and she was told that she is positive and when she went home she told him that the results were not good and he needed to know his status. He refused. In December 2002 he started beating her and abusing her badly.*

(Female client aged 26, 2004)

*She told him she had visited a VCT and she was negative and if he wanted to sleep with her he had to go to one. His attitude changed. The co wife used to frustrate her. The husband told her to go back to [her home district] or he would kill her.*

(Female client aged 41, 2004)

*Yesterday, the man beat her thoroughly and even pulled her hair out. He accuses her of her HIV status and tells everyone about it.*

(Female client aged 33, 2005)

Lack of knowledge among women and men about the symptoms and treatment for STIs appears to be an important barrier to health services. In some cases, such as the following, abusive partners appeared to be unaware of or in denial of the connections between their own reproductive health and that of their partners.

*[Her husband] forces her to have sex without her consent and for now her husband infected her with gonorrhea. [The client] went to the hospital for medication. She has asked him to seek medical attention but he has refused saying there is nothing wrong with him.*

(Female client aged 25, 2004)

There are also many cases of clients complaining of repeated marital rape leading to unspecified health problems, which may have been symptoms of STIs.

*She has been married for 12 years and blessed with 2 children. Her husband battered her and she now suffers from pains in her body, but her worst problem is the way her husband uses force on her to have sex and this hurts her badly because she suffers from the wounds he causes during forced sex.*

(Female client aged 30, 2003)

*The husband forces her with sex even when she's sick. Now due to sex violence her private part is bruised and has cracks which leads to a lot of pain.*

(Female client aged 30, 2004)

In some cases these undiagnosed pains and sores could be due to physical injury and bruising from sexual violence (Campbell 2002). But these symptoms are also likely to be caused by undiagnosed ulcerative genital sores relating to STIs such as herpes. Thus STI symptoms seem to be interpreted by some clients as the direct outcome of forced sex, not the impact of complications arising from untreated STIs. Therefore many women appear to lack information on the health impacts of marital rape, and the need to quickly treat STIs to avoid complications. Some women may not be aware that the symptoms they are experiencing are due primarily to unprotected sex in a context of violence, not a direct outcome of the violence itself.

However, other clients experiencing marital rape are aware of the risks of HIV and STIs involved in unprotected forced sex, yet feel unable to take action to reduce this risk.

*Her husband forces her to have sex even if she refuses. This is one of the main reasons for the continuous abuse. She says she knows he has many girlfriends and sleeps around a lot. She knows of HIV/AIDS and does not want to get it but in her efforts to avoid getting any diseases she is severely beaten up. She says she cannot leave because she does not have a place to go.*

(Female client aged 36, 2004)

Most client records did not mention whether or not clients had attempted to use condoms, but in contexts of forced sex, negotiation over condoms is likely to be particularly difficult for the reasons described above. A few records did mention this issue explicitly.

*[The client] claims that her husband has only physically abused her once but her main problem is the way her husband forces her to have sex when she's on her monthly period. She says that this problem has resulted in HIV and she asks her husband to use a condom he refuses totally.*

(Female client aged 25, 2000)

### **5.2.2 Intimate-partner violence and pregnancy**

Physical and sexual violence against pregnant clients by intimate partners featured frequently in WRAP's records. There are many cases of pregnant clients being hit, pushed, kicked, threatened with weapons, strangled, and in less common cases, attacked with pieces of wood, knives, metal bars, and furniture. The main health impacts of violence during pregnancy described by clients were bleeding and miscarriages. Most of the client records did not provide information on the specific complications involved. Studies from around the world indicate that intimate-partner violence against pregnant women causes miscarriage, late entry into prenatal care, premature labour and childbirth, foetal injury, stillbirth, and low birth weight (Krug *et al.* 2002).

A few of the cases demonstrate the interrelation of forced sex and resultant STIs with maternal health problems.

*When she became pregnant she developed a dislike for this man. He started calling her a prostitute. He would beat her up when she had not done dishes by the time he came home. He had other girlfriends but denied it. He would insist on forced sex. She lost the baby as a result of stress and abuse. She has syphilis caused by him. She conceived again but lost it at two months. She has had the disease for long and has blisters on her vagina.*

(Female client aged 20, 2003)

There were cases of husbands ignoring the health risks of violence during pregnancy, or continuing abuse even after complications, or after operations such as caesarean sections.

*In August she went to the guy's place and she told him that she wanted to stay there and he said that she could not. He became hostile and started beating her in front of neighbours. She told him to stop as she was bleeding. She slept and in the night he forced himself on her in spite of the bleeding.*

(Pregnant client aged 22 years, 2003)

A few clients miscarried on more than one occasion due to violence from the same partner.

*They started having domestic problems during her first pregnancy and the husband used to beat her when he got drunk to an extent of her having miscarriage. The husband was sorry for what happened and apologised and she forgave him. On her second pregnancy the husband started his beatings, forcing her to procure an abortion.*

(Female client aged 18, 2004)

A particularly striking trend in the data was that pregnancy often appeared to trigger the onset of psychological abuse, physical violence and rejection by intimate partners. A large number of client records described psychological and physical abuse beginning around the time the client became pregnant. Even more frequently, clients described being abandoned or thrown out of the house by their partners when they became pregnant, and this action was often reinforced by violence.

*Things were well until [the client] became pregnant, when the man started drinking and sleeping out and stopped providing for the family as well. When she was only six months pregnant, the man beat her thoroughly until she started bleeding. He refused to take her to the hospital claiming that he did not have any money.*

(Female client aged 28, 2005)

*[The client] has been living with her boyfriend for two years. She conceived and had to abort since the man told her that he did not want children. She is pregnant again and the man has told her that he does not want to marry her and that he has a lot of things to do. He has told her to leave the house and go on her own way and kill herself if she so wishes. He left the house not leaving her a cent and yet she had not eaten the previous night.*

(Female client aged 30, 2003)

### **Box 5.3 Insecurity of accommodation and vulnerability to abuse during pregnancy**

*In April when I was six months pregnant, I went back to my home because [my husband] said he didn't want see me in his house with a pregnancy. He would beat me and call me a maid. I would sleep on the floor and without food. I stayed at [my parents'] home until I had my baby. The man and his family then came and pleaded with my parents to let me go back. I relented and life was quite bearable until I conceived again. When I broke the news of my pregnancy, he got mad and told me I know the trend, leave his house. On 1st, he beat me and stepped on my stomach saying he wanted the baby to come out. Fortunately, the neighbours intervened. He keeps on threatening me [...] I want shelter but one month is too short. Where do I go after one month?*

(Female client no age recorded, 1999)

*Her husband forces her to have sex and if she does not do as the husband says she would be beaten to the extent of raping her, which it has made her suffer from stomach pains internally. She also has eye problems due to the blows she gets from the husband. She claims she cannot leave because she's expecting [a baby]. She wants WRAP to call her husband over and caution him about raining blows on her while she is expectant as she is already feeling the discomforts of the pregnancy.*

(Female client aged 20, 2002)

### 5.2.3 Violations of the right to make autonomous decisions about one's own fertility

In addition to violations of individual's autonomy and dignity, violence against WRAP's clients violated their rights to make autonomous decisions about their own fertility. This included intimate partners using violence to dictate decisions about whether or not to become pregnant and whether or not to have abortions, and obstructing them from accessing and using SRH services, including contraceptives and treatment for STIs. Unintended pregnancies were occasionally mentioned as resulting from marital rape.

*She has lived with the husband for 7 years and blessed with 2 children. Her husband battered her with a rungu [club] and raped [her, which made] her pregnant. She wanted to abort but her in-laws stopped her. Later she left her husband for her own rescue.*

(Female client aged 31, 2003)

There are also cases of intimate partners using violence to dictate decisions about family planning and having children, violating their right to determine their own fertility.

*The husband raped her and she conceived. On realising this, he is insisting that she aborts, and she has refused. He then started beating and mistreating her.*

(Female client aged 22, 2005)

*When she was 2 months pregnant [her husband] was furious and told her to go for an abortion. She refused and he beat her up seriously.*

(Female client aged 18, 2003)

In some cases, intimate partners were violent in response to reproductive issues, including infertility, or in cases of violence triggered by pregnancy, described above.

*She gave birth and the child passed away. Since then she has not conceived again. Her in laws are up in arms against her and they want her gone [...] Her husband also began to be violent in 1996 when he saw no baby coming.*

(Female client aged 30, 2004)

*I have a disease of giving birth to only girls. I have a total of five girls who have brought a lot of disgrace to me. My husband's family despise me because of them and my husband has joined forces with them. Several times he has threatened to kill me and my children because we are of no value.*

(Female client 2000, no age recorded)

Kenyan law prohibits abortion in all but a few circumstances. In addition, the law is ambiguous and even where the law might theoretically provide for legal abortion, as in the case of rape, formal, safe services are not readily available (FIDA 2002b). WRAP's data involves cases of clients who sought unsafe

abortions after being made pregnant due to rape by fathers, intimate partners, and strangers. In a few cases, examples of health complications from unsafe abortions are documented.

Young women, including girls aged under 18 years, appear to be particularly vulnerable to sexual and reproductive rights violations associated with violence. In a number of cases of pregnancy arising from rape, adolescent girls were pressurised into seeking unsafe abortions, with further risks to their health.

*[When the client was] 17 years [old, she] had nowhere to go since [...] her mother got married again and could not live with her. [...] She met a man who started living with her and made her pregnant. He then asked her to abort since he did not want responsibilities. She refused and he starved her until she decided to give in to back street abortion. It affected her and she became very sick but eventually recovered. Although she agreed to do what he had asked her to do, he still mistreated her and she felt fed up and wanted to leave him but did not have anywhere else to go.*

(Female client aged 17, 2000).

#### **5.2.4 Impact of abuse on health seeking behaviour and access to services**

The psycho-social impacts of abuse may have indirect but severe effects on SRH outcomes, by affecting the choices women make about dealing with the impacts violence or taking action to end or prevent future abuse.

Some of WRAP's clients described feeling unable to do anything on their own, suggesting that the abuse had lowered their sense of self efficacy. Others described hopelessness or fatalism around the violence or its health impacts.

*The [client's] husband has been beating her up and she has developed pains in her body. Her husband abused her sexually and infected her with HIV virus. She has been going to the hospital to get treatment for the infections she got from her husband. She cannot leave because her both parents are dead and has nowhere to go. She also says that since she is positive she knows that inevitably she will die.*

(Female client aged 45, 2004)

Such feelings of hopelessness generated by constant exposure to health risks in a violent relationship may lead some clients to avoid or delay seeking the health information and care they need.

*[The client's] late husband used to force her into sex, which resulted into fights. [She] was not comfortable with her husband since he used to have signs of sexually-transmitted disease. The death of her husband made her go to VCT centre so as she could know her status and that was when she found she was positive.*

(Female client aged 28, 2000)



The psychological impacts of intimate-partner violence are often aggravated by both the repeated nature of violence within relationships, and taboos around sexual violence, as many women do not feel able to speak out about the violence.

*Her husband strangles her with his legs and hand, then forces her to have sex in a very rough way; this has led to some problems while walking or going to the toilet. She's now saying that the silence has killed her slowly and decided to come to WRAP for help.*

(Female client aged 27, 2003)

Economic abuse by partners often appeared to aggravate the sexual and reproductive health problems caused by abuse. There were frequent cases where WRAP's clients complained that their husbands were neglecting them financially, taking their earnings, preventing them from working or sabotaging their income-earning activities. Clients often described difficulties in paying for treatment of SRH problems and of husbands refusing to pay for their medical bills. This included difficulties in accessing treatment for STIs, despite the fact that in Kenya, such services are provided at no charge in government health facilities.

*[The client's] husband hit her on the head with blows and forces her to have sex even when she's not willing to. She has never had medical attention since the day her husband infected her with a sexually transmitted disease. This is because she cannot afford it.*

(Female client aged 20, 2000)

*[The client] has been married for 5 years blessed with 2 children. Her husband beats her up with a belt and even bites her. Her husband has infected her with a sexually transmitted disease. [The client] says she's in the marriage because of the children. She says that she has not been cured of the STD and wants medical assistance.*

(Female client aged 22, 2001)

Many clients complained that they were using traditional herbal treatments for STIs and other health problems associated with abuse, saying that they could not afford to pay for medical fees.

*She was advised to talk to her husband and ask him to take her to Kenyatta hospital for further scans but he told her that he would only give her fare to go home and get herbal treatment.*

(Female client aged 20, 2003)

Intimate-partner violence therefore violates the full range of sexual and reproductive health rights defined in international law, both directly, through violence, injury and infection, through cruel and degrading treatment, and by undermining the right to choice about reproduction, and indirectly, by undermining access to health services. The following three sections examine how rights are defined by individuals and in social and legal arenas, and how far these dimensions of rights support or constrain individuals in ending violence and realising their sexual and reproductive health rights.



### 5.3 Personal definitions of rights and responsibilities

Women's personal understandings of their own entitlements and expectations relating to marriage<sup>7</sup> are an important point of departure for understanding their decision-making about how to respond to cases of violence from their partners. During repeated reading of WRAP's client records, we found that perceptions about marital roles played a salient role in the ways women framed their relationships with abusive partners. Claims about the differential obligations and entitlements of husbands and wives within marriage were the primary ways in which WRAP's clients defined their own rights and described the abusive behaviour of their partners.

WRAP's records suggest that women's perceptions of the right to be free from physical and sexual violence from their partners vary, and are sometimes constrained by societal tolerance of male violence against women and concepts of sexual obligations within marriage. Among WRAP's clients who believed they had a right to be free from violence, many described being forced to subordinate this to their material needs and those of their children, because of their financial dependence on their partners. Episodes of violence were often triggered by women pressurising husbands about unfulfilled marital roles. Their husbands' economic responsibilities to provide for their wives and children were widely recognised, whereas fidelity was only sometimes described as an obligation of husbands. WRAP's clients frequently described themselves as having an entitlement to commitment from their partners, or in other words, having the entitlement not to be abandoned. They repeatedly referred to their right to receive child maintenance in the event of separation, and many believed that they have a right to compensation if their husbands leave them.

From client records, it is clear that clients had strong beliefs about the responsibilities of husbands and their own corresponding entitlements as wives. Problems with partners were frequently described in terms of failure to live up to these responsibilities.

*She claims that her husband does not carry out his duties and obligations as a husband. She claims that the husband is a drunkard, does not want to look for a job and always wants to make love to her by force, whenever she denies him sex, he calls her a prostitute.*

(Female client aged 38, 2005)

The entitlement to expect material support from husbands emerged as a universally held value. WRAP's clients often described failure to cover the costs of rent and food as the most serious ways in which their husbands did not live up to their marital responsibilities.

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<sup>7</sup> Cohabitation is commonly viewed as a form of marriage in Kenya, and the vast majority of WRAP's clients who were affected by intimate-partner violence described themselves as married.

*My husband is irresponsible and violent most of the time. I am the one who buys food and pays rent and I feel strongly that I should not pay rent for a man.*

(Female client, 1999, age not recorded)

Some case histories mention forms of neglect that suggest clients have strong views about the emotional responsibilities husbands have to their wives and families. These include allowing wives to fulfill their own marital roles, such as cooking for their husband, not drinking excessively, and not staying away for the night.

*They lived well until last year when he started changing. He stopped speaking to her, and only communicated to her through her daughter who is now ten years. He moved from their matrimonial bed and went to a separate room. She also says that he cooks his [own] food and does everything for himself.*

(Female client aged 35, 2005)

Clients who experienced health problems due to violence from their husbands often considered it particularly bad that their husbands did not pay for their treatment.

*She claims that on 12th December last year her husband beat her thoroughly until she miscarried. He did not take her to the hospital and instead asked the neighbour to do so, claiming that he would settle the bills which he has not to date. She says that she did not heal properly. She claims that he does not feed them or care for them any more.*

(Female client aged 23 years, 2005)

*He dragged her and beat her seriously. He beat her even when she was pregnant and he did not pay the hospital bill.*

(Female client, 2003, age not recorded)

This suggests that a belief in a wife's entitlement to healthcare from her husband is more clear and straightforward than beliefs in her entitlement to be free from violence. Cases like this may even indicate an unstated belief that husbands have some entitlement to hit their wife within certain limits, and if these limits are exceeded, then husbands' obligations include payment for treatment of the resultant injuries.

Similarly, clients often referred to the expectation that partners should behave reasonably. Many clients spoke of circumstances where partners behave in a controlling way, restricting their economic and social activities. Clients often referred to beatings by husbands over petty or unfair issues in their descriptions of the events leading up to violence. A common example was beatings relating to problems or accidents over which the client had no control.

Some, but not all, of WRAP's clients had a strong belief in their right to be free from sexual violence from intimate partners. In some cases, clients believed they had the right to choose not to have sex with their partners when they were not 'in

the mood'. However, in many cases, clients described certain circumstances where forced sex was seen as particularly bad, for example, when they were sick, or when they were menstruating, implying a partial notion of the right to sexual autonomy. In some cases, a male partner's refusal to have sex was seen by female clients as an example of emotional neglect by their intimate-partner, implying a belief that both partners have the right to consensual sex with their partners. This implies a corresponding obligation to provide sex to partners in all but a limited number of circumstances. The limits to some clients' own perceptions of their sexual autonomy within marriage are demonstrated in the following case:

*[The client's husband] got another lady. He has stayed with her [...] on and off. When he comes home to [the client] he demands sex by force and he does not use a condom. She said that she complies to his demands as she is legally married to him in the church and she says he has kept the marriage certificate away from her.*

(Female client aged 30, 2004)

A particularly frequent trend in the data is for physical abuse to be triggered when women challenge their partner about their failure to live up to marriage roles, including not providing for the family or questioning husbands about extra-marital affairs.

*She says that around April, he beat her up and hurt her badly, due to the fact that she wanted to know why the man was neglecting his duties as a husband.*

(Female client aged 24, 2005)

*When she reminded [her husband] of the rent, he beat her.*

(Female client, no age recorded, 2000)

Clients appear to see this as particularly unjust, possibly because they are being beaten for a problem caused by their husband's failure to live up to his obligations.

*She claims that in August this year she asked him to feed her, for her condition does not allow her to stay hungry for long. Instead he beat her and chased her away.*

(Female client aged 25, 2005)

Affairs were frequently mentioned by clients as a problem in their relationships with their husbands. Clients often mentioned affairs as one of the ways that abusive husbands were failing to conform to their marital obligations. However, with a handful of exceptions, clients did not usually describe their husbands' infidelity as their main reason for seeking WRAP's services. In many cases, women have tolerated extra-marital affairs for a long time before coming to WRAP about a different issue.

One source of particular emotional suffering appears to be where husbands bring other women to the house and to the matrimonial bed. The cultural significance of

the marital bed perhaps indicates that there are norms about where and when extra-marital affairs are regarded as definitely unacceptable and what wives' entitlements are.

*She claims that her husband mistreats her by chasing her out of the house and brings women into the house and most of the time sleeping with them on his matrimonial bed.*

(Female client aged 23, 2005)

In many cases, extra-marital affairs or other marriages began to be seen as a problem by clients when they led husbands to neglect their other marital roles, for example when it led to sleeping away at night, disappearing without explanation, failing to provide for the family materially, or refusing to eat with the family. In other cases, clients were particularly concerned about infidelity because of the threat of STIs including HIV, as described in Section 5.2.

One of the biggest marriage problems for many clients was their partner's failure to commit to them. This sometimes involved their partners avoiding marriage, having other partners, and refusing to have children together. In other cases, clients were abandoned by their partners when they became pregnant. Clients tended to regard commitment as a right both partners earned by investing time in relationships. Women's perceptions of their personal entitlements as wives are in some cases broader than their legally-defined rights, for example beliefs about the right to compensation for abandonment following a relationship that was not formalised.

*She claims that for the 10 yrs they have stayed together, he has not wanted her to have a child with him, he has not even once committed his life to her and does not provide for her either [...] [The client] is asking for legal advice, so that the man can compensate her for wasting her time, [by] claiming that he would marry her but [failing to do so] when [the] time comes.*

(Female client aged 35, 2005)

*[The father of client] said his daughter disappeared from home and a few days later a lady and a man came to his place and they told him they had his daughter. The fellow married her and he impregnated her. [The husband later] chased her away. [...] [The client's father] wanted to know what could be done to this man for dumping his daughter.*

(Female, age not recorded, 2003)

A husband's failure to provide materially for children was frequently the main reason for a client's visit to WRAP, and this is considered by WRAP staff to be a form of emotional abuse in itself. In most cases, clients did not refer to their partner's obligations under Kenyan law to provide for his children and were often not aware of the legal limitations to these rights, an issue that we return to in Section 5.5. In a substantial number of cases, client's views of their rights stretched beyond their legal rights, for example where unmarried couples had separated and the ex partner had not accepted responsibility for the children.<sup>8</sup>

### 5.3.1 WRAP's client's responses to violence

There were repeated cases of WRAP's clients describing how their economic dependence on their husband and their lack of alternative accommodation limited their options for leaving the abusive relationship. In many cases, clients requested that WRAP help them to find a way of earning a living.

Many women appear to subordinate their rights to be free from violence, and, indirectly, their SRH rights, to the economic imperatives of material survival and providing for children. This is despite the fact that children may also be affected emotionally and physically by the violence.

*[The client's] husband has been abusing her physically, the last time she was hit by a rungu [club] and her hand was broken. [...] [The client] claims that her husband forces her into sex [...] [She] says she has not been able to leave the marriage because she has no job and the husband is the one who supports the children.*

(Female client aged 20, 2000)

*Her husband beats her up till her lips swell [...] He also forces her in sex of which he has now infected her with HIV virus. She is currently expectant. [...] She says she cannot leave the house since she has nowhere to take the kids and also the fact that she is pregnant.*

(Female client aged 25, 2002)

WRAP's clients repeatedly complained of feeling 'stranded' when their husbands stopped providing them with shelter. The dependence of many women on men for accommodation is an important part of the environment in which abuse is tolerated.

*She says that now she is stranded and does not know what to do.*

(Female client aged 23, 2005)

*She came back to WRAP having left us in 28th October 2003. She went back to her husband because she could not find anywhere to stay. [...] The abuse started [again] almost immediately.*

(Female client aged 24, 2004)

In many cases, clients wanted reconciliation with abusive partners who had abandoned them. This is to the extent that some clients want WRAP to mediate to try and save their relationship even where husbands have affairs, neglect and physically abuse them, and even abandon them. There were much fewer cases of clients wanting to separate from abusive husbands.

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8 Under Kenyan law, proof of paternity does not, by itself, establish a legal obligation on the part of a man who has fathered a child. This has been the position since the repeal of the Affiliation Act, in 1969.

*She claims that her husband was always beating her until the day he sent her packing and married another woman. She left her matrimonial home in the year 1982. She is saying that she can only go back to her husband only if he would love her.*

(Female client aged 53, 2005)

*[The client] claims that the husband beats her over small house issues. He does not want to provide for her and the children. [...] In March, 2005, she left the husband for Mombasa [...Her husband] said that when she left, he thought that she had left for good and hence had to look for another lady to marry. [...] She wanted the husband to be summoned to our office so that he may say his stand according to his marriage and [their] children.*

(Female client aged 21, 2005)

Clients often referred to entitlements to supportive interventions by their family or their husband's family in cases where their husband had failed to live up to his marital responsibilities, and had treated them in an unjust way. Parents and parents-in-law were expected to encourage abusive husbands to change their ways. In cases where husbands failed to change their behaviour, parents were expected to allow their daughters to leave the marital home and to stay with them. The extent to which their expectations of support were fulfilled is explored in the following section.

## 5.4 Social dimensions of rights

In Kenya and other East African countries, social networks of extended family and community are traditionally supposed to intervene in cases of violence, and provide protection and support to help individuals to end violence that is considered to be unacceptable (Hirsch 1998; Ekeh and Gage 2000). Client's accounts of seeking help from social networks, and the response they received, reveals the complex and mixed record of social networks as a protective resource. Women's families and relatives-in-law, and members of the community sometimes helped, sometimes denied women's rights or were complicit in rights violations, and sometimes tried to help but were not able to solve the problem.<sup>9</sup> In general, women's own family were more likely to support their rights than were their husband's relatives. However families also sometimes subordinated WRAP's clients' wishes to end the abuse to other issues, such as the economic imperatives of the family as a whole. Some rights defined in international law tended to be absent from the social dimension. For example, the right to be free from sexual violence was not always recognised by family members.

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<sup>9</sup> By the nature of the data, WRAP clients are likely to be those who failed to solve their problems through the support of their family. The data used in this study may therefore under-represent the extent to which families do help clients to realise their rights.



Clients described appealing to both family members and relatives-in-law to intervene by speaking to their husbands. There were a few examples of cases where this support was forthcoming and effective.

*Her husband sexually harassed her [...] She was lucky that her in-laws spoke to him then he changed his habit.*

(Female client aged 42, 2003)

There are many cases where the client's family attempted to help them, but this did not succeed in ending the violence. Family protection appears to be particularly limited in cases of recurrent and extremely abusive behaviour.

*Every time [the client's husband] beats her and notices that he has hurt her, he calls her relatives and solves the matter with them, and this has gone so far that she could not hold on any more. She claims that on 14th August 2005, the man threatened to kill her with a knife.*

(Female client aged 24, 2005)

Similarly, the interventions of relatives-in-law were often ineffectual.

*It became worse when she asked him when he was going to pay dowry and formalise their marriage. He beat her up even before his father and when his father asked him to stop he told him to go and deal with his [own] wife.*

(Female client aged 28, 2003)

In other cases, families failed to help the clients at all. In some cases this was due to financial factors, particularly where parents prevented their daughters from returning to them because they did not want to have to return the brideprice that they had received when the couple got married in a customary ceremony.

*Her husband battered her and abused her sexually. [...] She talked to her parents about this and they said that she has to persevere because the dowry was already paid and she could not leave the marriage.*

(Female client aged 34, 2003)

In some cases, relatives claimed that the violent behaviour is normal, thus encouraging clients to limit their conceptualisations of their own rights.

*She has been a victim of violence and [forced] sex. Her husband forces himself on her during sex and if she happens to refuse she ends up getting hurt more. Her private parts are now swollen and very painful due to the forced sex. She told her relatives and they said that it's part of life.*

(Female client aged 28, 2005)

There are many cases of in-laws refusing to help and encouraging clients to 'persevere' with the marriage despite the violence.

*Her husband battered her several times resulting in stomach pains because of the kicks on her stomach. She has even been bedridden for nearly a month*

*because of the pain. She has got a sexually transmitted disease and she has already gone to the hospital for treatment. Her in-laws tell her to persevere with her marriage.*

(Female client aged 28, 2002)

In some cases, relatives-in-law intervened to prevent WRAP's clients from leaving abusive relationships, or joined in the abuse.

*When she was only five months pregnant, [her husband] became violent and beat her to the extent that she had to move and find another place to live with her other four children. She says that she was doing well alone, before his relatives went for her and forced her to go back to him. She says that the man is not cooperative and all he does is pay rent only. She conceived again late last year and he became violent again.*

(Female client aged 34, 2005)

Social networks appear to be put under strain when women are pregnant or when they have small dependent children, as families and friends were often unwilling to allow women who are in these circumstances to stay with them, limiting their options for avoiding violence during pregnancy.

*She complains that her husband has chased her away with two children. Presently she is 2 months pregnant. She went to her parents but her father could not allow her into the family, so, he chased her away too.*

(Female client aged 27, 2005)

In some cases, families are complicit in the violation of clients' rights, for example by supporting the marriage of minors to individuals who have abducted them.

*She claims that she was tricked by a man who told her to accompany him to go and visit his sister, a friend she was at school with. [...] He forced her to his bed and defiled her until she bled. [...] [The client] then took the man to the chief and there he said that he was ready to marry her and take care of her. He later took her to her parents, who after hearing the story asked him why he brought her back. He said that he brought her back because she took him to the chief and this annoyed him so much.*

(Female client aged 15, 2005)

Cases like this reveal that in the social dimension, the right to consensual sexual relationships is often fragile or non-existent, and may be subordinated to economic or social factors.

The ambiguous nature of the social dimension of rights brings the danger that perpetrators can claim that forms of abuse are cultural practices in an attempt to 'legitimate' their actions. In WRAP's records, this included cases of child sexual abuse that perpetrators tried to claim were marriages, totally in breach of Kenyan law, which clearly states that there is no consensual sex with anyone aged under 18 years.



*[The client] started living with her aunt 5 years ago when her mother died. [...] The aunt's husband started abusing her sexually when she was still young. He was using force to sleep with her and if she refused, he was threatening to throw her out of his house and deny her food. [...] The abuser [...] admitted that he started sleeping with the minor this year and that there was nothing wrong since he had discussed the issue with the wife who agreed that [the client] will be the 2nd wife. [...] The client says that if she reports to the aunt that she is being defiled, the aunt tells her that she is his wife [...] [The uncle] said that the girl was given to her by her father and the wife gave the permission.*

(Female client aged 15, 2005)

Some clients also describe appealing to community members, such as neighbours or church elders for support to deal with violence. There are many cases of clients being saved from physical attacks by neighbours. On very rare occasions, neighbours are involved in the abusive behaviour. Similarly, churches were a source of support or rejection in different cases. In a few cases, informal justice or vigilante groups were mentioned as intermediating in violent relationships.

The social dimension of rights appears to be weak and ambiguous in the experience of WRAP's clients. From among WRAP's clients, orphans, and others with weak social networks, refugees and adolescent girls often appear to have particular difficulty asserting their rights in the social domain, and are therefore particularly vulnerable to intimate-partner violence. In the following extract, a client describes the failure of multiple strategies to realise her rights in both the social and legal spheres.

*She claims that her husband beats her so much and she has reported to both of her parents, the husbands parent's, the area chief, the church elders as well as to [a legal rights NGO] but nothing has come out of all these...*

(Female client aged 30, 2005)

## 5.5 Rights in the national legal context

This section examines both the extent to which national law recognises and protects SRH-related human rights, and the accessibility and functioning of justice institutions. As with the social sphere, WRAP's data demonstrates that both legal rights and justice institutions play a variable and often ambiguous role in protecting clients from abuse.

### 5.5.1 National legal framework

WRAP's client records mention a wide range of legal issues that relate to violent relationships, including child maintenance, property and inheritance disputes, divorce, and child custody, as well as criminal cases over the violence itself. This range of issues highlights the interrelated nature of rights, and demonstrates that for individuals to end violence and realise their sexual and reproductive health rights, their other rights must be protected in legal frameworks.

Despite some protection of relevant rights in Kenyan national law, including the outlawing of some forms of violence and new legislation on the responsibility of fathers to provide for their children, the implications of legal institutions for WRAP's clients were found to be mixed. There are gaps in the law, which limit an individual's ability to protect themselves from violence or leave violent relationships, and laws relating to child maintenance, assault and sexual offences remain poorly implemented.

Marital rape remains unrecognised in Kenyan law, which has failed to prohibit forced sex within marriage despite the introduction in 2006 of a new Sexual Offences Act designed to tighten the law on sexual violence (Government of Kenya 2006a). A clause relating to marital rape was dropped when the bill was debated in the National Assembly, following heated discussions about culture and rights. Many parliamentarians asserted that in Kenyan culture, there could be no such thing as rape between spouses (Wrong 2006). The controversy surrounding this aspect of the bill, and its rejection by parliamentarians reveals the lack of social acceptance of the right to sexual autonomy for married women. The only legal protection for women in cases of marital rape is the general law on assault, which requires evidence of a physical struggle or witnesses. WRAP's case histories reveal the law is inadequate for protecting women from marital rape, as clients describe seeking to avoid repeated violence by not struggling, or remaining silent during sexual violence from their husband to protect their children from witnessing the abuse.

The Sexual Offences Act is in the early stages of implementation and has not yet been evaluated, but WRAP's experience to date suggests that, at the time of writing, it is not yet being applied by the police because they regard it as too complex and lack training to implement it. As a result, police officers tend to revert to the provisions on physical assault in the Penal Code, which are poorly designed for addressing cases of domestic violence, making prosecutions more difficult.

In Kenyan law, marriages are recognised if they involved certain customary, religious or legal ceremonies. For those cohabiting without these marriage ceremonies, the law provides for common law presumption of marriage, but this has to be demonstrated in court, which means individuals in such informal 'marriages' are much more vulnerable to rights denials in the event the relationship breaks up if they cannot afford to pay for legal processes to defend their rights (Kabeberi-Macharia and Nyamu 1998). Indeed, many women who are cohabiting regard themselves as married, without realising that this may limit their ability to secure child maintenance for their children (Kabeberi-Macharia and Nyamu 1998). There are 269 of WRAP's clients for whom information on the legal status of their relationship was recorded in their case history. Of these, 51 per cent (138) were in cohabiting relationships, 28 per cent in customary marriages, and 21 per cent in formal marriages. Of the 138 women who were recorded as cohabiting, 70 per cent explicitly defined themselves as married, suggesting they may have been unaware of the lack of legal status of their relationship.

*[The client] got married to her husband in the year 2001. He got her from school. [...] The man started changing. He would spend the nights out, became rude and violent and would not provide her with anything. He finally*

*told her that he does not want her any more. He abandoned her and left the house. She was starving and could not pay rent. [...] She wants to be helped so that the man can see on how he can maintain her or even give her money to start her life off again. [...] She was advised that forcing the man to help her would not work out, especially since they have not yet formalised their marriage.*

(Female client aged 21, 2005)

Some clients explained that their partners avoided formalising the marriage by legal or customary ceremonies.

*She claims that her husband has always been a drunkard, a wife abuser and a non-provider. She claims that they have property [...] and all are under his name. She married him customarily but every time she tells him to officiate it he is always so reluctant, saying that he does not believe in church marriage.*

(Female client aged 55, 2005)

In one case in 2003, a client described how abuse from her husband worsened when she asked him to pay dowry and formalise the marriage.

The Children's Act, enacted into Kenyan law in 2001, covers child maintenance, paternity and custody. The inclusion of child maintenance responsibilities in this act was a contested political issue, and the issue of responsibility of fathers to children in informal marriages was particularly contentious. Women's and child rights organisations are at the time of writing advocating for reform of the 2001 law on the grounds that the Children's Act discriminates against children born out of wedlock. Key informants from the legal aid NGOs CRADLE and FIDA both emphasised how there are limits to children's rights in cases of informal marriage, as in such cases, fathers are only liable to pay child maintenance if they were cohabiting with the mother at the time of birth. The law also fails to protect the rights to child maintenance of children born to couples who split up during the pregnancy. In Section 5.3, we described how in many of WRAP's case histories, clients felt unable to leave violent relationships because they did not believe they could provide for their children on their own. Thus the Children's Act has remedied the situation for only some categories of women and children.

The Kenyan Penal Code outlaws abortion, except Section 240, which states that it can legally be performed if the physical or mental health of the mother is in danger (Centre for Reproductive Law and Policy 1997). This law is ambiguous, and may be interpreted to include cases where conception occurred as a result of rape or other sexual violation, but there is no explicit guarantee of this (FIDA 2002b; Government of Kenya 2004). The ambiguity around the law means that information and safe, accessible services are not readily available, undermining the ability of individuals to access safe abortion even in cases where they might be legally eligible. The majority of abortion services used by Kenyans continue to be informal, unregulated and unsafe. The law therefore exposes women in abusive relationships to the risk of unsafe informal abortions. Section 5.2 demonstrated linkages between intimate-partner violence and unsafe abortion in cases where physically abusive husbands force their partners to have unsafe abortions. As marital rape is not recognised in Kenyan law, even if abortion is

provided for in the case of rape, the rights of women living in abusive marriages would not be protected.

In some cases, the perceptions WRAP's clients held about their rights were wider than those defined in Kenyan law. In a few cases, clients sought help to enforce sexual and reproductive health rights that they believed themselves to be entitled to, but which are not protected in law. The case of marital rape was one such example.

*The husband also abuses her sexually and now she experiences sore wounds on her private parts. [...] She wants to know if there is any law that can be used to address this use of force by her husband. [WRAP's staff informed her] that the only law which takes care of this is limited to assault and she would need to get a [police medical report] and follow the procedure of a criminal case.*

(Female client aged 39, 2004)

*Her husband abused her sexually and infected her with HIV virus. This infection she had from the husband has made her suffer from continuous bleeding. The problems stopped when she was advised to leave her husband. She wants to know if she can get her husband to compensate her for the pain and suffering and for the fact that he has infected her with the HIV virus.*

(Female client aged 39, 2004)

### 5.5.2 Justice institutions

Justice officials who interpret, apply and enforce the law are active in defining what legal rights mean in practice. Frontline justice officials such as police and local administrators are particularly important gatekeepers of individual's access to justice, and in some cases defined clients' rights more narrowly than national law.

Police played a particularly varied role in WRAP's client case histories. In many cases, police and chiefs were supportive of clients, and helped to protect them from rights violations. In others, police took little action, refused to take action without receiving a bribe, or took ineffective measures.

*She has ever gone to the police who talked with her husband in vernacular and told her that the case is solved. This was in 2001. Since then the husband has never reformed.*

(Female client aged 26 years, 2005)

The police generally appeared to be more responsive in the case of rape of minors than with intimate-partner violence, and were often (though not always) quicker to take action. This may be linked to a lack of belief that intimate-partner violence is a crime. In some cases, police refused to take action because they deemed the violence a 'domestic matter' that should be resolved in private.

*He [The client's husband] came home drunk and started to argue on small issues. [...] I was beaten so much and I was bleeding all over. [...] I was taken to police station who advised me to go hospital and then sort out the problem at family level.*

(Female client 1999, age not recorded)

Cases such as the following reveal that many justice officials base their actions on socially-constructed beliefs rather than national law.

*He told the police he beat her up and this was because of her behaviour. The OCS [Officer in charge of a police station] then refused that they go to court.*

(Female client 2004, age not recorded)

In other cases, police were directly involved in violating clients' rights. This included colluding with abusers, by arresting, on false charges, women who went to the police for help. In some cases, the police tried to intimidate clients into withdrawing cases against their abusers. In a few cases, police were alleged to have carried out violent attacks on clients, including rape and other forms of sexual assault. It should also be noted that the client records may not capture failings by justice officials that occur later in the legal process. For example, even if the police file a report on the matter, there may be a lack of cooperation in processing the case.

Clients frequently described seeking assistance from their local administration to end violence from their partners or to resolve disputes that involved violence. Chiefs in Kenya are appointed local administrators, who often function as a default court for resolving family disputes over issues such as child neglect, adultery, child custody and property disputes following separation, particularly where couples are not formally married. In marital or child custody disputes, the role of chiefs is to facilitate consensual agreements, but these have no binding legal force. In Nairobi province, chiefs deal with more cases of domestic violence than do the police (COVAW 2002).

WRAP's data demonstrate that chiefs sometimes define women's legal rights more broadly than national law, demanding that husbands live up to their commitments to their wives, for example by returning to wives they had left. However, in many cases, though chiefs take action to help clients, this action is often not enough to end the violence or to realise clients' rights. The chief's office is a 'default' forum for dispute resolution. It is not formally mandated to resolve disputes and it is therefore not equipped with legally recognised and obligatory measures for follow-up and enforcement. Enforcement largely depends on the personal commitment of the person in office, and therefore effectiveness of the forum will vary from chief to chief (Nyamu-Musembi 2003). In WRAP's experience of collaboration with local administration, decisions made by chiefs can be overruled by police and courts. In some cases, chiefs are frustrated and demoralised by their lack of power to deal with domestic violence issues effectively.

*[The client] went to the chief and reported. The chief then summoned the man but he did not hearken to him. That's when she was given a letter to come to our office for help.*

(Female client aged 25, 2005)

*She claims that she has suffered so much because her husband does not provide for her and her children. She claims that [...] her husband had married another wife and together they had four other children. She went and reported the matter to the area chief and the children's department who summoned the husband and together they agreed that he would be sending her 2,000 shillings every month [...] She has never seen him since then.*

(Female client aged 25 years, 2005)

In other cases, chiefs refused to take action, arguing that the case was a private affair, or siding with men who question the paternity of their children.

*She claims that she has been in a relationship with a thirty year old man who promised to marry her when she became pregnant. After she became pregnant, she asked the man and the man responded by buying the unborn baby clothes [...] She claims that on 11\01\05 she received a letter from the area chief summoning her to go and meet him. On reaching the chiefs office [...] she was told that the man claimed that he does not know her, and does not know where she got pregnant.*

(Female client aged 21, 2005)

## 5.6 Service delivery for survivors of violence

WRAP's approach to service delivery is based on an awareness of the constraints in the individual, societal and legal dimensions of rights, and clients' need for long-term support in order to overcome these constraints. WRAP often refer clients in stages, asking them to come back to the office to report on how a referral went and to get further advice if the referral had not had the intended results. This involves providing informal advice to clients about how to deal with their situation and how to make best use of institutions and services, and developing a plan of which actions to take first. Sometimes WRAP's staff accompany clients on referrals to the police and other institutions to advocate on their behalf.

In some cases, this extends to playing a watchdog role to ensure that the police and local administration fulfil their roles.

*[The client] went to [a partner organisation] but this organisation referred her to the police. She took the case to the police, but the police wanted money for petrol for her to be helped. She then decided to go back to the [partner organisation], which referred her to WRAP. They wanted WRAP to talk to the police so that they could have the man arrested.*

(Female client 2005, age not recorded)



WRAP mediates with abusive husbands and family members on behalf of clients. This is particularly important in Kenya because of the central role that the social context plays in either helping or constraining individuals affected by violence. The social dimension of rights is also important because of weaknesses of legal frameworks and justice institutions. It offers alternative, though imperfect, mechanisms for protecting rights. In cases where both social networks and legal frameworks do not adequately protect abused women, for example in cases of child maintenance relating to unmarried couples, or in cases of marital rape, WRAP's options for supporting clients are often limited.

### **5.6.1 The referral system**

A well-functioning referral system is of critical importance for assisting women affected by intimate-partner violence. For many of WRAP's clients, the problems relating to abuse are multi-faceted, and violence can only be ended and SRH rights realised through multiple avenues. For example, clients may need alternative accommodation, legal aid to secure child maintenance, medical assistance, and rehabilitation services in order to leave an abusive relationship and deal with the associated health problems.

WRAP's records reveal many positive examples of effective coordination between different service providers, such as cases where WRAP provided shelter for clients while specialist legal aid NGOs dealt with their legal issues. However, there are also examples of inappropriate referrals to WRAP where problems are outside WRAP's mandate, and of ineffectual referral from organisation to organisation. Some clients had to see four or more providers in order to access the help they needed. The network of service providers for survivors of violence has no system for coordination. Sometimes there seems to have been a lack of clear understanding of each other's mandates and priorities among organisations offering various types of services, leading to inappropriate referrals.

Key informants at the NGOs CRADLE, CREAW and COVAW all noted that the network of services for survivors of violence is currently overwhelmed by demand for its services and lacks capacity to meet the demand. This network includes legal advice NGOs, rehabilitation NGOs such as WRAP, and NGO and government medical services for dealing with gender-based violence. The Kenyan government does not currently provide or fund legal aid or other support services for women affected by violence. It may be that the pressure to report high numbers of completed cases to donors has created an incentive among NGOs to refer cases without adequate attention and a disincentive to engage in cases that require long-term action. WRAP's staff have found that cases are referred to them without adequate attention because they are complex and not easy to resolve. Certainly, legal aid NGOs have to select their cases carefully, according to the likelihood of success, and the NGO network may not be so well adapted for more complex cases that require engagement across the various dimensions of rights, or where the law fails to protect clients.

These weaknesses in the referral system run counter to the need to streamline services and reduce the number of steps a woman needs to go through to access help (Mayhew and Watts 2004). This is of critical importance in services for



survivors of violence, as multiple and inappropriate referrals may reduce the likelihood that clients will seek help from organisations to which they are subsequently referred. Box 5.4 provides examples of clients who sought help from a number of social actors and organisations in order to access the help they needed. Others experiencing similar setbacks or complications may have given up along the way.

#### **Box 5.4 Paths to justice or trails of tears?**

The following cases provide an example of the various social and legal institutions and service providers that clients might have to approach, in order to address the problems related to abuse.

*In December, he chased her out of their matrimonial home. She then called an elder in the home to intervene. He intervened but nothing changed. [Her husband] even tried scalding her with hot water [...] He chased her out at one a.m. and she went to her neighbours. She went to her pastor and that same elder but her husband refused to see them. So they gave up and asked her to make up her mind on what she wants. Her pastor then referred her to Nairobi Women's Hospital (NWH) where she was counseled. [NWH] sent her to CREAM and she filed for separation. He has started looking for her. She went back to NWH and that is when she was referred to WRAP. She was admitted at the shelter home.*

(Female client aged 33, 2003)

*My husband beat me last night because I asked him for money. These beatings have been going on for a very long time. He beats me at the slightest mistake or excuse. [...] In one of these occasions, I reported the matter to the police, but the police officer (a lady) told me that I deserved the beatings. [...] His people do not see our problem as a serious one and my mother advises me to persevere. I have reached a point of no return and want to move out. What worsens the problem between us is that he is promiscuous. This makes me reluctant to sleep with him hence the beating.*

(Female client 1999, age not recorded)

Financial constraints are a major factor restricting the ability of NGOs in Nairobi from meeting the demand for their services. WRAP, for instance, is sometimes unable to help clients who are rightly referred to them for secure accommodation, despite the fact that without access to shelter, these clients are vulnerable to violence. The holding capacity of WRAP's shelter is up to 40 women and children, and inevitably, WRAP have to set restrictions on the length of their stay.<sup>10</sup> This is particularly a problem for pregnant women, as WRAP are unable to cover the cost of medical care for delivery, or provide accommodation for homeless pregnant women beyond the six-week period they are offered shelter.

### **5.6.2 Sexual and reproductive health services for women in abusive relationships**

Many of WRAP's clients are unable to access treatment for sexual and reproductive health and other medical conditions and WRAP has limited options for helping these clients. At the time of writing, WRAP has medical funding for the treatment of injuries arising from abuse and a few specific health conditions where they affect shelter residents, including colds and malaria. They have no resources available to address sexual and reproductive health conditions, some of which are among the most expensive of health costs experienced by WRAP's clients. A key informant from the NGO CREAW confirmed that these constraints also affect other NGOs in Kenya.

Specialised medical services for people affected by gender-based violence focus on emergency care, leaving WRAP with limited options for referring clients who are late in reporting rape, or who have chronic conditions arising from abuse. Organisations providing comprehensive post-rape care tend to prioritise cases presented to them within 72 hours of an attack, because such cases enable the effective provision of emergency contraception and HIV and STI prophylaxis, and allow for the preservation and collection of evidence for prosecution of offenders. Cases that fall outside this timeframe are not prioritised, and there is no provision for chronic health conditions arising from abuse (Government of Kenya 2004; Key informant interview LVCT). Individuals affected by ongoing abusive relationships, such as intimate-partner violence, therefore have to rely on general health services. Standard health charges apply, and for some conditions these are prohibitive for most Kenyan women.

Research on a short-lived policy of charging fees for STI treatment in Kenya found that the introduction of heavily subsidised fees had a negative impact on use of services, indicating that even small costs might deter many users (Moses *et al.* 1992). Although, at the time of writing, STI treatment is officially free of charge in government clinics, many of WRAP's clients claimed they could not afford to treat the STIs they had contracted in abusive relationships. Women may find these clinics to be stigmatising, particularly clinics that are staffed by people from the same community, preferring to go to private clinics that charge for services (Standing 2002). In other cases, services that are officially exempt from user charges may be subject to informal charges or may not be sufficiently publicised (CRR and FIDA 2007). A voucher system currently being piloted in Kenya, the Output-Based Aid (OBA) initiative, is a much-needed investigation of a potential financing mechanism for overcoming access barriers by providing economically disadvantaged and abused women with subsidised/free treatment with their preferred service provider. The scheme, led by the National Coordinating Agency for Population and Development (NCAPD) currently focuses on maternal health, general family planning services, and counselling and treatment for injuries caused by gender violence. It does not currently cover treatment for sexually transmitted infections or other health problems caused by gender-based violence. For women who are abused or abandoned during pregnancy, access to antenatal

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10 The maximum length of stay in the WRAP shelter for adult women and their children is six weeks.

and assisted delivery services is particularly important, yet the relevant exemptions and waivers in the government healthcare system are currently inadequately publicised, and many eligible women are not aware of them (CRR and FIDA 2007).

Experiences of poor quality services and stigma may further undermine health seeking behaviour. A recent study of obstetric services in Kenya found poor standards and human rights abuses in government facilities targeted at poor women (CRR and FIDA 2007). A study carried out in 1991 suggested that high rates of failure in the management of STIs in public and private clinics in Kenya could be an additional factor causing delays to the treatment of STIs, pointing to a need to strengthen the effectiveness of services at the first point of contact with the health system (Moses *et al.* 1994).

## 6 Discussion

### 6.1 Contextualising rights in cases of intimate-partner violence

As outlined in Section 5.2, the experiences described by WRAP's clients reveal that intimate-partner violence violates all aspects of sexual and reproductive health rights defined in international human rights law. In itself, intimate-partner violence violates the rights to liberty and personal security, to privacy, and to be free from sexual violence, torture and other cruel, inhuman and degrading treatment. Intimate-partner violence leads to violations of rights to sexual and reproductive autonomy, including the rights to plan one's own family, and to be free from violence, discrimination and coercion in relation to sex and reproduction. WRAP's client records also demonstrate that intimate-partner violence both directly and indirectly violates the right to health and reproductive health, because of the direct impacts of injury and infection, and because it can reduce an individuals' access to health services and undermine their health-seeking behaviour.

In reviewing 1,253 of WRAP's client records, we have found that the rights of women in all three dimensions (personal, social and national legal framework) are limited in both content (scope in relation to international definitions of human rights) and in practice (the extent to which rights are protected and realised within each dimension). As expressed in the claim that human rights are indivisible and interrelated, a full range of rights needed to be protected in the social and legal spheres in order for WRAP's clients who were affected by intimate-partner violence to be able to claim their sexual and reproductive health rights.

WRAP's client records reveal that Kenyan women appear to draw substantially on the customary and social dimensions in their personal articulations of rights, and many have limited knowledge of their legal rights. WRAP's data suggests that many Kenyan women have strong views about the obligations of their partner to fulfil a range of socially constructed gender roles. The extent to which their own sense of entitlement coincides with international human rights standards is mixed. Few of WRAP's clients appear to believe they have a fundamental right not to be

beaten or forced into sex by their partners. More believe in the right not to be beaten or forced into sex in unfair circumstances, and the definitions of acceptable and unacceptable circumstances appear to vary in nature and degree between different individuals. Other research in Kenya has found that in all Kenyan ethnic traditions, limited forms of 'corrective' violence against women by their husbands in specific circumstances are considered to be legitimate (Hirsch 1998; Center for Reproductive Law and Policy 1997). A qualitative study carried out in three locations in Kenya in 2003 found that attitudes to rape within marriage are diverse, but that many individuals, including many females, believe that rape cannot occur in marriage because marriage involves automatic consent for future sex (Kilonzo 2003: 37). Some of WRAP's clients defined their rights in ways that are not recognised in international legal frameworks, including the right to sex with their partner and the right to commitment from partners when they had invested time in the relationship. Entitlements to sexual fulfilment and pleasure were never mentioned by WRAP's clients. There were particularly divergent beliefs about the right to fidelity from one's partner.

In practice, women face multiple constraints that undermine their ability to claim and realise their rights. As found in other research on Kenya (Johnston 2002), episodes of violence were often triggered by women challenging their husbands about unfulfilled marital roles. In this context it can be particularly dangerous for women to articulate their marital entitlements to their partners. Clients tended to emphasise their fulfilment of socially constructed domestic norms of 'good women' as a tactic for countering violence from husbands. There are limits to such an approach, as it may not help to counter the gender inequalities women are experiencing within their relationships, and cannot address forms of violence that are socially sanctioned or tolerated, including 'corrective' violence by husbands against wives and marital rape. Many of WRAP's clients described long paths to justice, having to seek help from many different sources, including social networks, and legal, health and other services providers, in order to end the violence and to mitigate its effects. These clients described how they repeatedly encountered barriers to claiming their rights in each of these different spheres. Negotiating these spheres, often with limited knowledge of legal rights and available services, could be compared to trying to find one's way through a labyrinth, where one repeatedly encounters dead ends. In this context of multiple obstacles, women frequently subordinate their rights and entitlements to be free from violence to other imperatives such as accommodation and material survival for themselves and their children. In contexts where help from institutions and the social networks often has limited results, pursuing rights may be risky, as ineffective assistance might return clients to a situation that has been aggravated by taking this action. This gives an indication of the context within which women make decisions about which rights to claim and when.

The frequency with which WRAP's clients describe appealing to family members to intervene in cases of abuse demonstrates that in Kenya, this aspect continues to be considered an important strategy for dealing with violence. However, WRAP's records reveal that there are often limitations to the role of traditionally protective social institutions in cases of long-term abusive relationships. For example, there were many cases of families or families-in-law failing to support clients, taking ineffective action, or even directly violating individual's rights.

There appears to be ambiguity and variation about which human rights are protected by the social domain. The right to be free from physical abuse was often limited to cases judged to involve 'unjustified' or 'excessive' violence. In some cases, families supported women's right to be free from sexual violence, in others they did not. Some family and community members encouraged clients to limit their view of their rights, urging them to 'persevere' with abusive relationships where they are repeatedly experiencing infections with STIs, or telling them that marital rape is 'just a part of life'. Hirsch (1998) has noted that women in Kenya's coastal areas are under social pressure to 'persevere' or silently bear husband's transgressions. This concept narrows women's socially-constructed entitlements for countering intimate-partner violence. Hirsch (1998) and Silberschmidt (2001) have found that women in some Kenyan ethnic groups are considered to have a stronger entitlement to economic support than to fidelity from their husband. It may be that focusing on material neglect by male partners enables women to transfer their marital problems into the public domain and gives them 'license' to speak out about less public issues such as infidelity or abuse and seek intervention by relatives. The limits to the effectiveness of these social practices point to the need for organisations such as community and religious groups to publicly address intimate-partner violence as a social and moral issue, and for gender bias in laws and justice institutions to be eradicated.

Poverty was frequently cited as a problem that led the families of WRAP's clients to subordinate individual's rights to material imperatives, including insisting that women remain in abusive relationships, or refusing to take in pregnant women who have been abandoned by their partners. The payment of brideprice was repeatedly described by clients as a factor that restricted their rights within marriage, particularly by limiting social acceptance of the right to be free from violence and coercion in relation to sex. More research is needed to understand the relative importance of cultural and economic factors among different communities within Nairobi, which is a city characterised by ethnic diversity and exposure to international mass media. FIDA report that around 10 per cent of their clients state that such attitudes in their communities undermine their ability to leave abusive relationships (FIDA 2006).

WRAP's client records reveal that the realisation of women's legal rights is essential in order for many women to be able to end intimate-partner violence and realise their sexual and reproductive health rights. The legal problems experienced by some of WRAP's clients reveal a range of limitations in both the content of Kenya's national legal framework, and the functioning of the justice system in practice. Despite legal reforms in 2001 and 2006, introducing the Children's Act and the Sexual Offences Act respectively, Kenyan law still ineffectively protects human rights and discriminates against women and children. Limitations to the content of laws include inadequate or ambiguous laws on child maintenance, abortion and sexual violence within marriage. WRAP's records repeatedly demonstrate how the weakness in the Children's Act for children of unmarried cohabiting couples severely restricts the options of women affected by intimate-partner violence for ending the violence. WRAP's clients who were cohabiting were frequently unaware of the limits to their rights, revealing the need to raise awareness about the legal implications of cohabiting. This trend was also noted in a study of FIDA's client records, which found that many women only



discover the legal distinction between cohabitation and customary marriage when marital problems emerge requiring the intervention of 'legal' forums in which these distinctions make all the difference (Kabeberi-Macharia and Nyamu 1998).

The social dimension impacts on the legal dimension in numerous ways, undermining the scope to reform national laws in order to recognise certain sexual and reproductive rights, and influencing justice officials to discriminate against abused women on the basis of socially-constructed gender norms. The removal of the marital rape clause from the Sexual Offences Bill when it was debated in Parliament during 2006 reveals the constraining impact of the social dimension of rights on prospects for legal reform. WRAP's client records provide powerful testimony to the debilitating physical and mental health impacts of marital rape, which are frequently overlooked in public debates on legal reform. Evidence on the pain, distress and health problems caused by marital rape, including poor maternal health, repeat-infections with STIs and long-term exposure to the risk of HIV infection, may help to reinforce rights-based arguments that forced sex within relationships *is* rape.

Justice institutions including police and local administration have a mixed record, ranging between helping clients, taking inadequate measures, refusal to help and direct involvement in violating the rights of women by supporting their abusive partners. It appears that, in addition to the resources and capacities of justice institutions, their effectiveness depends on the personal attitudes of justice officials, and on the economic and social resources (networks and influence) at the disposal of the individuals for asserting their claims.

## **6.2 Health services for women affected by intimate-partner violence**

The multiple barriers WRAP's clients describe in accessing services and realising their rights point to the need to standardise services provided by institutions dealing with intimate-partner violence, to strengthen and formalise the referral system between institutions, and to train officials in gender and rights awareness. There has been initial progress in this direction. There have also been advances in institutionalising standards and systems between the health and legal sectors through the introduction of national guidelines on 'Medical Management of Rape and Sexual Violence' (Government of Kenya 2004). The NGOs CREAM, COVAW and FIDA have been carrying out training activities with police to raise their awareness of rights and gender. But the sector for dealing with gender-based violence remains severely underfunded, and progress will be slow unless greater government commitment to addressing this problem is forthcoming.

Different types of gender-based violence tend to result in different combinations of sexual and reproductive health problems, although there is considerable overlap between them. This study suggests that at the level of designing policy responses, a key distinction needs to be made between long-term violence within relationships and single episodes of violence. Violence within relationships brings the problem of recurrent exposure to SRH problems combined with the potential for restricted access to SRH services. The most common SRH problems

associated with intimate-partner violence mentioned by WRAP's clients are STIs and HIV infections, trauma of the vagina and reproductive tract, and complications during pregnancy. Many clients had not received professional medical attention by the time of coming to WRAP, and described a variety of undiagnosed symptoms such as genital sores, pain urinating, pain during sex, discharge and chronic abdominal pains.

WRAP's records reveal that health services for women affected by intimate-partner violence are complicated by a number of factors. In some cases, abusive partners refused to go for STI tests or to seek treatment. This was sometimes compounded by abusive partners behaving violently in connection to sexual and reproductive health issues or denying clients the resources to pay for healthcare. WRAP's records also suggest that clients do not always understand the health impacts of forced sex, and had limited knowledge about the symptoms and treatment of STIs. This lack of knowledge is a cause for concern as it might undermine abused women's demand for treatment for STIs, risking further complications (Moses *et al.* 1994). This supports arguments for prioritising interventions to raise public awareness about STIs (and also about the availability of treatment free of charge), as well as targeting STI information and services to women affected by intimate-partner violence.

Research on fatalism about HIV prevention finds that when individuals repeatedly experience lack of success in their efforts to control stressful life-events or when intolerable situations remain unchanged, they are likely to experience feelings of hopelessness about their chances of protecting themselves from HIV and therefore fail to take action to look after their health. Fatalism can be caused by 'learned helplessness' when 'efforts to control stressful life-events are continuously unsuccessful and when intolerable situations remain unchanged' (Meyer-Weitz 2005: 76). It is therefore unsurprising that WRAP's clients who complain of severely limited sexual autonomy within relationships, or whose efforts to secure help to end the violence in the social or institutional spheres have repeatedly failed, describe feelings of hopelessness about seeking treatment for STIs or preventing STIs and pregnancy.

This has implications about how services are targeted and delivered. Many women in abusive relationships are repeatedly exposed to sexual and reproductive health problems, necessitating services that are as accessible as possible. This need becomes even greater when women are also affected by economic abuse and feelings of hopelessness about their health. Specialised initiatives targeted through mainstream health services may be needed to overcome these multiple barriers to access experienced by many survivors of gender-based violence, and encourage demand for services. This may include schemes to waive or reduce user fees for women affected by violence. Despite the provision of free STI treatment in government clinics, many clients complained that they could not afford treatment for STIs, suggesting that there may be problems with acceptability and accessibility of government health facilities or informal charges (Standing 2002). Preliminary experience with the Output-Based Aid voucher scheme in Kenya indicates a much lower uptake of post-rape care services than with family planning or assisted delivery services (Kichamu and Kundu 2008). The reasons for this are poorly understood, pointing to the need for



more research on how violence affects demand for and access to health services and how these services can be made readily accessible for abused women.

The question of how best to provide reproductive health services for ongoing cases of abuse is complex, particularly in health systems where resources are limited. There are dilemmas about the level at which to provide these services within the health system, and challenges in targeting individuals affected by violence and providing quality services that are integrated into general health services. Most health providers in Kenya do not routinely screen clients for violence and do not collect information on the SRH conditions that are caused by violence. There is a need to strengthen the capacity of mainstream health service providers to identify, treat and refer those affected (IPPF 2004; Mayhew and Watts 2004). Because of the long-term recurrent nature of violence in many abusive relationships, there is a fundamental need for medical staff to refer clients to rehabilitation and legal services, to help them to break the cycle of violence and ill health. Given the likely logistical and resource limitations for introducing national schemes to cover costs of SRH services for women affected by violence, overcoming biases and providing basic training to health service professionals may offer an appropriate first step (Mayhew and Watts 2004), which could help to overcome fears and anxieties some women experience about stigma from service providers.

### **6.3 Vulnerability to intimate-partner violence**

The barriers and rights violations in the social and legal spheres discussed in Sections 5.4 and 5.5 help with understanding how various forms of vulnerability undermine individuals' ability to claim their rights in all three dimensions, limiting their options for protecting themselves from violence, and for mitigating its SRH impacts. This can include vulnerability to the onset of abuse, its duration, and inability to deal with the impacts, including by accessing health care.

WRAP's data strongly suggests that pregnancy can be a time of increased risk of physical abuse, neglect and abandonment in Kenya. This conforms to trends noted in other parts of sub-Saharan Africa, where pregnancy has been found to be a time of increased risk of certain types of violence, although there is considerable variation across and between countries (Mayhew and Watts 2004; WHO 2005). Financial independence, particularly lack of alternative accommodation, make pregnant women especially vulnerable. The onset of violence during pregnancy may be linked to high rates of cohabitation among WRAP's clients. Pregnancies that were unplanned and/or occur in cohabiting relationships may be particularly likely to be associated with episodes of violence, a situation that is exacerbated by the legal vulnerability of cohabiting women. The 2003 Kenyan Demographic and Health Survey found that 45 per cent of births were unwanted or mistimed (CBS 2004a), and the figure is likely to be higher among women in cohabiting relationships than those who are married.

This study concurs with findings from other studies in Kenya and other Southern and East Africa countries (Amnesty International 2002; Kilonzo 2003; Maman *et al.* 2002; Dunkle *et al.* 2004) on HIV positive status as a risk factor for violence, as

well as violence increasing women's risk of HIV infection. Those with weak or unsupportive social networks also appear to be particularly vulnerable to intimate partner violence, including adolescent girls, orphans and refugees.

The study findings indicate the need for more research on the causes of intimate-partner violence. This includes the need for studies on why some men in Kenya appear to favour forced sex over consensual sex. This will not be a comfortable discussion to engage in, but the number of times that the issue surfaces suggests that it is a problem that cannot be ignored. Indeed, the Kenyan Demographic and Health Survey found that 12 per cent of ever-married women reported being raped by their partner in the past 12 months (CBS 2004b), demonstrated that the problems described by WRAP's clients affect a considerable proportion of Kenyan women. Researchers are beginning to explore the impacts of masculinities and other factors in fueling intimate-partner violence, as well as potential interventions to address this (Barker and Ricardo 2005; Heise 1998; Silberschmidt 2001), but further research is urgently needed on marital rape in particular. Many of WRAP's clients' accounts of the violence suggested that economic and social pressures on men can cause tensions over their gender roles, leading to violence. Links between male violence and sexually aggressive behaviour and pressure to conform to ascribed social roles as breadwinners in a context of high levels of unemployment have been observed in studies of masculinity in urban and rural contexts in Kenya, Tanzania and Uganda (Silberschmidt 2001; Ezeh and Gage 2000; Johnston 2002).

Similarly to the findings of a study by FIDA (2006), WRAP's records reveal that material factors, including poverty or economic dependence on their partner, frequently push abused women into making a trade-off between economic survival and their right to be free from violence. For many women, sexual and reproductive wellbeing is unfortunately regarded as a secondary priority to basic material needs, with damaging consequences for themselves and their children. Here, the major constraints to the realisation of sexual and reproductive rights are the denial of other material rights, and women's lack of skills, confidence and resources that prevent them from believing that they can survive economically and socially on their own. One of the most striking trends from WRAP's data is the linkage between insecurity of accommodation and sexual and reproductive health risks, including inability to protect oneself from STIs and other SRH problems associated with violence. Women who are cohabitating rather than legally married are discriminated against in the law, and may find it difficult to claim child maintenance from estranged husbands, particularly if their husband throws them out of the house when they become pregnant.

Research studies in other contexts have not found consistent associations between household-level poverty and intimate-partner violence (Kishor and Johnson 2005), but community-level poverty and deprivation appear to be significant risk factors for domestic violence (Gage 2005; O'Campo *et al.* 1995; Miles-Doan 1998; Cunradi *et al.* 2000; Pearlman *et al.* 2003). The majority of WRAP's clients come from urban informal settlements, characterised by high levels of unemployment, poverty and physical insecurity. More research is needed to understand the community risk factors in such contexts. The diverse impacts that urban poverty in Nairobi has on a related issue to intimate-partner violence,

that of multiple sexual partnerships and HIV risk, are explored in Dodoo *et al.* (2006). These community-level factors may play an important role in linking socioeconomic exclusion, masculine identities and gender-based violence.

The finding that women often subordinate their rights to material concerns demonstrates that legal and policy measures to empower women to have increased control over their lives are needed to help women escape violence without suffering severe economic and social losses. Obviously, overcoming dependence on (male) kin would be an important and foundational step towards reducing the disincentives to women's pursuit of justice in matters of personal relationships, including sexual and reproductive health matters. But overcoming dependence requires measures much broader than the subject matter addressed in this paper.<sup>11</sup>

The barriers we have identified must be tackled in multiple ways, because the violations of these rights are founded on gender inequality in the social and legal spheres. Encouraging and strengthening use of community-based forums offers a partial but affordable and relatively accessible solution. In some cases women have successfully used these forums to air marital conflicts that would normally be kept secret, because this type of forum tends to be seen as 'less public' than the formal legal sphere and as commanding social legitimacy (Hirsch 1998). On the other hand, we are aware of the weaknesses of such forums, and unevenness of results. Various studies note the tension between these forums as reproducers of gender inequalities and as having the potential to be used strategically by women in claiming their rights and entitlements (Nyamu-Musembi 2002, 2003; Hernández Castillo 2002). At the same time, we also need to invest in the effectiveness of day-to-day formal institutions and procedures, for instance through decentralisation and adequate resourcing of services such as the Children's Department, and strengthening linkages with local administration.

## 6.4 Recommendations

Based on the findings of this study, the recommendations to the Government of the Republic of Kenya and other relevant organisations can be summarised as follows:

- **Multi-sectoral coordination**

Relevant ministries in the Kenyan Government should take action to strengthen standards and improve coordination between services for women affected by

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11 Microcredit schemes have been shown to be an effective way of reducing women's risk of violence in South Africa (Pronyk *et al.* 2006) and less traditional communities in Bangladesh, but not in more conservative communities in Bangladesh (Koenig *et al.* 2003). More research is needed to investigate appropriate economic empowerment strategies for urban informal settlements and other contexts in Kenya. In addition, well-functioning and fair justice institutions (both formal and informal) go a long way towards safeguarding women's livelihood security by upholding and extending the application of laws, customs and practices that do recognise women's entitlements to family property.

violence, including the Children's Department, health care providers, police and local administration, and legal aid and rehabilitation NGOs.

Service providers should take collaborative action to strengthen referral systems across all sectors relating to intimate-partner violence.

- **The health sector**

Interventions are needed to ensure that good quality and appropriate SRH services are accessible and acceptable for abused women, especially obstetric services and treatment for recurrent and chronic conditions caused by abuse.

The differing needs of women affected by both long-term exposure to violence within ongoing relationships and single episodes of violence should be considered in the design of health and other services.

The system of exemptions and waivers in the national healthcare system should be strengthened and better publicised.

Training of medical officers is needed to improve identification and referral of abused women.

Information campaigns are needed to raise awareness among men and women about the symptoms of STIs, the importance of early treatment, and where to access treatment.

- **Legal and judicial sector**

Reform of the Children's Act is required to remove ambiguities and discrimination in cases of children of couples that are not formally married.

Marital rape should be explicitly prohibited in national law.

The legal provisions regarding situations in which abortion is permitted need to be made clear, and the supportive services made accessible.

There is need for continued training and awareness-raising among justice officials on human rights and how to use the Sexual Offences Act.

- **Intimate-partner violence prevention**

There is need for violence prevention interventions that work with men by using a gender perspective to change attitudes and behaviour.

Religious and community leaders should publicly address domestic violence in all its forms as a social and moral issue.

Locally appropriate interventions are needed to help women affected by intimate-partner violence to become financially independent.

- **Funding for services**

Increased resource allocations are needed from the Kenyan Government and other donors for services to prevent violence, to help abused women to leave

violent relationships and to mitigate the effects of abuse, including sexual and reproductive health impacts.

Resources to address the needs of groups that are most vulnerable to ongoing intimate-partner violence are particularly needed.

## 7 Conclusion

This paper used existing NGO client records to explore the relationships between intimate-partner violence and sexual and reproductive health rights for women in Nairobi. Qualitative and basic descriptive quantitative analysis was carried out to explore the impacts of violence on health and to examine the obstacles encountered by WRAP's clients in realising their rights in the personal, social and legal domains. The study has demonstrated the potential of using non-conventional approaches to researching violence against women, particularly using pre-existing data collected during service delivery.

WRAP's client records provided powerful insights into women's experiences of intimate-partner violence and its impacts. Intimate-partner violence violates the full range of internationally recognised sexual and reproductive health rights, both directly through violence, injury and infection, through cruel and degrading treatment, and by undermining the right to choice about sex and reproduction, and indirectly, through undermining access to health services. This study found that the strength and legitimacy of women's rights in personal, social and legal dimensions and the degree of protection afforded by social practices and legal institutions are very mixed in Kenya. Individuals lack knowledge of their formal legal rights, and their sense of entitlement to be free from violence is viewed in relative terms that permit or excuse violence in particular circumstances. In comparison to international human rights law, the rights that are recognised in social norms and in national law are frequently limited both in content and in the extent to which they are protected in practice by social networks and judicial institutions. In this ambiguous and often arbitrary context, WRAP's clients described encountering repeated obstacles to claiming their rights in social networks and justice institutions and from service providers.

Various forms of vulnerability, including economic dependence, insecurity of shelter, lack of legal status of cohabiting relationships, and weak social networks, can make it particularly difficult for individuals to realise their rights in the social and legal spheres. Vulnerable individuals are often forced to make painful tradeoffs between their rights to be free from violence and the imperatives of material survival, with the result that their sexual and reproductive health rights are subordinated to economic imperatives. The growing area of research on perpetrators of intimate-partner violence is much needed for increasing our understanding of the causes of marital rape and other forms of abuse and how to prevent them.

A particularly striking insight from WRAP's client records is that intimate-partner violence exposes women to recurrent sexual and reproductive health risks, and women affected may have particular difficulties accessing services, leading to

increased risk of chronic STIs and poor maternal health outcomes. The complexity of the medical needs of women affected by intimate-partner violence dictates that service provision needs to be designed to meet the needs of women affected both by long-term violence within relationships and by single episodes of violence. This includes both ensuring that general health services are more accessible for abused women and, where appropriate, providing specialised services to address chronic conditions brought about by abusive relationships.

Women often incur a high social cost in seeking justice and treatment for health problems associated with violence. Those women brave enough to risk the social disapproval and stigma that comes with taking measures to tackle abuse from their intimate partners should not then encounter further barriers in the labyrinth that is the referral system. There is urgent need to strengthen coordination among all relevant service providers.

The Government of Kenya, as the primary duty bearer for the human rights of Kenyan citizens, could do more to demonstrate its commitment by strengthening services for women affected by violence and by narrowing the gulf between human rights and the lived realities of women, through legal reform and improved implementation.



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